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ABSTRACT

Written by professional psychologists, the 10 articles collected in this bulletin focus on stressful experiences that, when inappropriately responded to, can result in developmental problems for children. Stress factors are conceptualized as being either direct or indirect, or internal or external. Articles are organized in terms of these four dimensions. Two of the articles discuss direct, internal factors associated with stress: organically based learning disabilities and children's self-defeating misperceptions of self and others. Seven articles focus on direct, external stress factors, including hospitalization, death, divorce, child abuse, birth or adoption of a sibling, school problems, and disastrous international and natural events. The remaining article, examining a type of indirect, external stress, indicates developmental stress points associated with increasing levels of exposure to media. Generally, all 10 articles, as well as the introduction, attempt to present the specific nature of the stress factor discussed, describe children's perceptions of and reactions to specific stressful life experiences, and delineate internal and external resources available for helping children cope with stress. Frequently, specific suggestions for intervention are provided for parents and teachers. (RH)

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CHILDREN & STRESS

Helping Children Cope

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CHILDREN & STRESS

Helping Children Cope

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INTRODUCTION

ABIGAIL STAHL MCNAMEE

Many life experiences are stressful to some degree. It is not possible, or even desirable, to eliminate all stressful life experiences from the lives of the children with whom we live and work. Children learn to cope with stress by moving through the anxiety they feel with the help of a supportive adult, often a parent or teacher. As positive experiences in dealing with stress accumulate, children develop the ability to see themselves as competent, strong, worthwhile individuals and to see life as a challenge they can meet.

Factors That Can Contribute to a Stressful Life Experience

Children experience a wide range of factors that *can*, but do not necessarily, contribute to a stressful life experience (McNamee and McNamee, 1981, pp. 182-85). Some of these factors are *internal*, coming from inside the child more clearly than from an outside source. This bulletin focuses on two categories of internal factors:

congenital organicity
mistaken, unhelpful and self-defeating perceptions of self and/or others.

Some factors that can contribute to a stressful life experience are *external*, coming from outside the child more clearly than from an inside source. Seven categories of external factors are here presented:

hospitalization of self or family member
death of another
divorce and family discord
child abuse and/or neglect
birth or adoption of sibling
school
larger community-world events

Internal factors are experienced only directly, but because they come from inside the child, he or she is central to the life experience and "lives" it first-hand. External factors can be experienced by the child directly as well, but they can also be experienced indirectly or vicariously through witnessing or hearing another's experience in real life or through media. It should be noted that internal or external factors are interactive in nature: internal factors affect external factors and vice versa. For example, a child who has a learning disability (internal factor) may be called "lazy" by parents, teacher, friends (external factors) and punished (yet another external factor). Another example: a child whose parents divorce (external factor) may see himself or herself as responsible for the divorce because he or she was not "good enough" (internal factor). The interaction can become increasingly complex if the factors just described are the experience of one child rather than two, both internal and external factors "stacking" in a child's life experience.

Whether a stress factor becomes, in fact, a stressful life experience for a child depends upon the internal and external resources available to, and utilized by, the child:

Internal Resources	the child's attributes neurological biological psychological
External Resources	the persons who intervene before, during and/or after exposure to a stress factor (friend, parent, teacher, counselor, psychologist)

Children's Perceptions of and Reactions to a Stressful Life Experience

Reaction to a stressful life experience is dependent upon the child's perception of self and of the experience, perceptions which grow during childhood as the child reacts to one or another stressful life experience, utilizing internal and external resources. Gradually a perception of self and experience evolves (McNamee & McNamee, 1981., p. 185):

The Child's Perception of Self

As one who:

is competent and strong

possesses the ability, power and control necessary to avoid, minimize or terminate an anticipated or actual stressful life experience

is helpless and vulnerable

does not possess the ability, power and control necessary to avoid, minimize or terminate an anticipated or actual stressful life experience.

The Child's Perception of the Experience

As one which:

is surmountable; a challenge

can be avoided, minimized or terminated

is insurmountable, a threat

cannot be avoided, minimized or terminated

A child grows in perceiving himself or herself as generally able or unable to manage and in perceiving stressful life experiences as facilitating or debilitating the ability to manage. The child's perception might be accurate or inaccurate based on real strengths or vulnerabilities or imagined ones (McNamee & McNamee, p. 187). There appear to be, roughly, three levels of coping ability:

Exceptionally Good Copers (Level I)

Children who cope easily with a stressful life experience, who recover spontaneously and integrate the experience into their life styles in a positive way, experience themselves as successful persons and build a resource bank of successful alternatives against which they can draw upon in coping with future stressful life experiences. Their belief in themselves as competent persons increase over time and with each new success.

Adequate Copers (Level II)

Children who have to work at coping with stressful life experiences often may or may not manage to integrate such experiences into their life styles in positive ways. Frequently they manage to cope adequately. When successful their self-confidence grows, but their successes are less frequent and their resource bank of successful alternatives grows more slowly than that of exceptionally good copers.

Exceptionally Poor Copers (Level III)

Children who become extremely disorganized by stressful life experiences may struggle much harder to surmount the experiences and seldom manage to build resources of alternatives for coping with future stressful life experiences.

Children coping at Level I are the least vulnerable; those coping at Level III, the most vulnerable. Children generally tend to cope consistently at one or another of these levels, but the ability of any child to cope with a particular stressful life experience may vary according to a "checkerboard of strengths and weaknesses" as described by Murphy & Moriarty (1976, p. 202) in their longitudinal study of vulnerability, coping and growth in children:

> Along the continuum of vulnerability, children may be distributed in different numbers: few if any are so robust, so completely lacking in small as well as moderate or major handicaps as to be totally free from

some zone of vulnerability. Most children have a checkerboard of strengths and weaknesses, or an "Achilles heel" or a cluster of tendencies that interact in such a way as to produce one or another pattern of vulnerability as well as strength.

When a child experiences a stressful life experience, he or she may react with physical symptoms (aches and pains, increased heart beat) and with psychological symptoms (anxiety, fear). Rollo May writes (1977, p. 113): "Anxiety is how we handle stress." The ability of a child to handle a stressful life experience successfully is evidenced by his or her moving into and through the anxiety confronted and moving on to other new and challenging life experiences. The inability of a child to handle such stressful experiences successfully "can deprive the child of essential learning experiences" (Wolff, 1969, p. xiii). The resources offered by a mediating or supporting adult, as a child is exposed to stress, become important for all children regardless of coping level; they become essential for children coping at Levels II and III. "It is not safe to assume the child will 'outgrow' his problem. It is wiser to know what if anything can be done to assure and to facilitate the process of outgrowing" (Josselyn, 1955, p. 366).

Resources To Help Child Cope with Stressful Life Experience

While internal resources provide the raw material necessary to cope with stressful life experiences, all children need to draw upon external resources, namely a supportive person. The task of adults wishing to help children cope with stress is not to attempt to eliminate stressful experiences from children's lives or protect them totally, but rather to try whenever possible to limit number and variety, intensity and duration of such experiences. Further, the adult's task is to provide immediate support and a bank of alternatives that the child may draw upon in the future.

A general sequence of possible mediating alternatives might become part of the adult's repertoire for helping a child cope (Woods/McNamee & Delisle, 1977, 1979). These alternatives begin with nonverbal interaction (allowing time to consider what might be said) and move toward verbal interaction:

- recognize the child's cue (a behavior change)
- be physically supportive (touching, holding)
- state or restate the situation (the stressful experience)
- share feelings (the child's and the adult's)
- give information (related to the stressful experience aimed at helping the child feel more secure)
- propose experiences (related to the experience)
- close the conversation (with the promise of re-opening).

The authors in this bulletin deal with specific internal or external stress factors in a manner that will help the reader understand the nature of the factor itself, children's perceptions of and reactions to the stressful life experience, and the resources available for helping the child cope with it.

ABIGAIL STAHL MCNAMEE

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DIRECT EXPERIENCE:

Internal Factors: Congenital Organicity

Stress Related to Organically Based Learning Disabilities

MARCY PERL SCHAFFER AND SYLVAN J. SCHAFFER

When a child with a learning disability encounters an unsupportive or threatening environment, a stressful life experience emerges. This article describes characteristics of children labeled as learning disabled; their perceptions of self as vulnerable, helpless and as having little or no control over circumstances; and mediation techniques for parent and teacher to use in helping the learning-disabled child to cope.

Interplay of Internal and External Factors That Can Contribute to a Stressful Life Experience

An organically based learning disability is one that often predisposes an individual to stressful life experience. Whether or not the youngster will experience stress, and the level of stress encountered, is a function of the child's interaction with the environment. When a child with a learning disability (internal factor) is faced with an unsupportive or threatening environment (external factor), a stressful life experience emerges.

Learning-disabled children are by definition those of average or above-average intelligence but manifesting mild to severe deficits in specific areas of functioning such as language, visual-spatial reasoning, memory, sequencing and motor function. They exhibit discrepancies in functioning, peaks and valleys in performance. Children with language disorders are often below grade level in reading and spelling but on grade level in math, whereas children with visual-spatial disabilities may be poor in math and word recognition but may have adequate reading comprehension skills. Such children are often misunderstood by adults and thought to be "lazy."

The type and severity of the learning disability determine the effect of the deficit on cognitive, social and other spheres of functioning and, therefore, affect the level of potential stress on the individual. Children having difficulty with expressive or receptive language are most impaired, since language is not only critical to higher cognitive functioning, but also mediates thought, self-control and behavior. A language-imparied child unable to express anger verbally may resort to physical outbursts. When language is deficient, communication with adults and peers breaks down, resulting in social difficulties and rejection. Adults may think a child with a receptive language deficit is "not listening" and get angry with the child. Many such children have difficulty in recogniz-

ing and labeling subtle facial expressions, moods and cues, which predisposes those children to interpersonal and social stress. Learning disabled children are often misunderstood and rejected by parents, teachers and peers (Bryan & Bryan, 1976).

While the cause of learning disabilities is unknown, a prevalent theory holds that it is a result of "minimal brain dysfunction" or subtle injury to the central nervous system that can result from anoxia or lack of oxygen at birth, high fevers, infections and other encephalopathic events. Contrary to popular belief, this organic deficit theory holds that the disability is not outgrown but rather lasts the course of the lifetime. The disability may, however, change forms; motor restlessness in the young child may turn into rapid mind racing in the adolescent. The underlying difficulty remains, predisposing the child to a variety of stresses.

Desiring to make their learning-disabled child "normal," parents often cling to the belief that the disability can be overcome if the child, school and all supportive professionals work hard, an assumption that can lead to harsh demands on the child, the school and outside professionals. Thus, learning-disabled children experience most stress when the disability is unrecognized, misdiagnosed or misunderstood by significant persons in their lives or when such persons cannot accept and come to terms with the disability and provide for the children's needs in supportive ways.

Learning disabilities often go long unrecognized. For many learning disabled children, unidentified until the older grades, feelings of frustrations and failures have become so compounded as to create emotional problems that go far beyond the original learning disability. Often, when the disability is unrecognized, parents and teachers at times make disparaging remarks. "You're lazy." "You're dumb!" They threaten the child with being "kicked out of school" and sent elsewhere. Some parents withhold affection, punish and express hurt in excessive ways, such as the mother who locked herself in her room every time her son brought home a disappointing report card.

Learning-disabled children are themselves aware of their deficits. They feel inadequate in comparison to their peers and generally experience school as stressful. Such stress is compounded, of course, when the significant persons in their lives continually express anger, disappointment and disapproval of their deficits.

Learning disabilities are often misdiagnosed and mistaken to be purely emotional or neurological in nature. While many such children benefit from psychotherapy and some from medication, these treatments alone without the proper educational environment are insufficient and do not get at the root of the problem. Many children labeled "hyperactive" and placed on ritallin because of restlessness in school do not show marked academic improvement as a result of medication. In fact, detrimental side effects of medication—lack of appetite and

fatigue—often create new stresses. Many such children are not neurologically driven during all activities; rather, their activity levels vary according to task difficulty. The fact that so-called hyperactive behaviors, such as foot tapping and restlessness, occur within deficit areas and often disappear during tasks, sapping areas of strength, suggests that the behaviors may be manifestations of anxiety or means of avoiding difficult situations. The view that "hyperactivity" may often represent an emotional reaction to learning difficulties suggests that ritallin treats the symptom, not the underlying cause. Thus misdiagnosis causes and exacerbates stressful situations, not only because it can lead to improper treatment, but because it results in the postponement of appropriate educational treatment.

A learning disability is a "hidden" handicap, so it is often unrecognized and thus untreated. When a physical disability is evident, parents and teachers can adjust expectations and minimize stress. With the learning-disabled child who appears normal in every way, it is often difficult to accept that there is a disability.

Parents who cannot fully understand and accept their child's disability and come to terms with their own feelings often develop unrealistic expectations and demands; they may become overprotective and/or rejecting. The overprotective parent underestimates the child's competence and overestimates the degree of danger in the environment. Overprotectiveness restricts a child's activities, interfering with the child's sense of mastery and control over the environment and attainment of independence. The child may be left feeling vulnerable and without resources to face new situations, such as leaving home for summer camp. The parents' wishes to protect the child from pain or fear may often reflect feelings of guilt that the parents are responsible for causing or exacerbating the child's disability and distress.

The rejecting parent may focus on the child's faults, making unfavorable comparison to other children. The child is seen as totally without ability so that nothing is expected or as acting less competent than he or she is capable of acting, so that harsh demands are needed to elicit appropriate behavior in expected ways. Such views make it difficult for the parent to be tolerant of the child or even show affection.

Learning-disabled children place greater demands on parents and the marital relationship and, being less responsive to even good parenting, contribute to the parents' sense of inadequacy. While mothers and fathers often take turns being overprotective and withdrawing, it is more common for mothers to be engulfing and fathers to be more distant and express little emotional attachment. It is noteworthy that the higher the socioeconomic level and aspirations of the parents, the more difficulty they have accepting the child's disability, which in turn exacerbates the child's stress.

Stress can still exist even when a learning disability is recognized and attempts are made to provide the most supportive educational and

emotional environment. Children in special education settings experience stress resulting from the stigma of being labeled as disabled and being segregated socially and physically from the mainstream by special transportation to school and special schools so that social interaction with non-handicapped children is minimized. But remaining in the mainstream can lead to other stresses: frustration, failure and rejection by teachers and peers. In either setting, there is still the frustration that the child cannot learn as well as he or she would like to. Moreover, ideal quality educational programs, techniques and materials do not yet exist for all handicaps and all populations.

The Child's Perception of and Reaction to a Stressful Life Experience

Since learning-disabled children often perceive themselves as vulnerable and as having little or no control over circumstances, they are generally unable to cope successfully with anticipated or actual stressful situations. They become demoralized in the face of failure. Previous unsuccessful experiences with their environment often reinforce the child's negative self-image and the view that stressful situations are insurmountable.

Feelings of inadequacy arise out of painful awareness of cognitive and social deficits and from the internalization of parental attitudes and perceptions of *them*selves. Children think they are a great disappointment to their parents. They do not differentiate their perceptions of themselves according to realistic strengths and weaknesses, but rather form their views of themselves as damaged and deficient. Many children with visual-spatial disabilities yet with adequate language and reading comprehension skills still feel inadequate in all areas.

A child's self-image of inadequacy can only be reinforced if a parent's emphasis on academic values is expressed thus: "Being good with your hands or in sports doesn't make you somebody; being good in school does." Results can be devestating to children internalizing their parents' unrealistic expectations and striving for heights they cannot achieve.

Unrealistic expectations of themselves condemn individuals to failure, reinforce their negative expectations of themselves and of life, thereby increasing their sense of despair. Emotional reactions to their learning disabilities and parental overprotectiveness often lead children to feel insecure in the face of stressful situations. Lack of experience with success and self-reliance makes learning-disabled children perceive many situations as threatening; they must look to others for help in overcoming these situations. They often want to be self-reliant and independent but are afraid.

Learning-disabled children's level of coping with stressful life experiences is a function of the severity of the disabilities, the supportiveness of the environment, their view of themselves and previous experiences

with confronting stress. While some may cope well, many are not so well adjusted and as a result develop self-defeating behavior patterns.

The following are examples of two self-defeating behavior patterns and their unconscious, mistaken goals or purposes (McNamee & McNamee, 1981, pp 1888-89):

Goal 1: *To avoid or hide feelings or inadequacy and shame.*

The child acts as if "I can't do anything . . . I have no chance to succeed . . . If I attempt something you'll discover how inadequate I am. I am better off not trying so that you won't discover what a failure I am."

Child's Reaction	*Child's Behavioral Cues*
Avoidance Withdrawal	Avoidance of perceived stressful events as a means of minimizing anxiety

The greatest fear of learning-disabled children is exposure of their inadequacies. Their motto: better not to attempt a task at all than take the chance of failing. Thus they develop ingenious methods of avoiding difficult tasks to save face: manipulating behaviors, daydreaming, becoming the class clown, engaging in disruptive behaviors. These behaviors occur more often within the child's areas of deficit than in tasks involving their strengths. Avoidance behaviors serve as a temporary defense but interfere with learning, making the child's fears of inadequacy a self-fulfilling prophecy.

Goal 2: *To obtain undue attention*

The child acts as if "I want to be noticed." "I want to be the center of attention."

Child's Reaction	*Child's Behavioral Cues*
Helplessness Over-reaction	Asking questions, crying for help, screaming, tantrums indicating feelings of being overwhelmed by stress and unable to terminate or overcome the situation without assistance from others.
Acting-out Disruptive behavior	Fighting, being disruptive, annoying others, clowning to obtain a reaction

Like all youngsters, learning-disabled children crave attention. When they can't obtain it through positive means, they often resort to acting helpless or acting out. Even negative teacher feedback—reprimands, anger—is still attention, placing the child in the center of things.

Research literature indicates that teachers generally seem reluctant to respond to the learning-disabled child's attempts to initiate an interaction, do not use more encouragement or praise for those in particular need of such encouragement and tend to give these children more negative feedback. For example Bryan (1974) found that teachers responded to only 43.6 percent of contacts initiated by learning-disabled children, whereas they responded to 76.7 percent of contacts initiated by non-learning disabled children. About 50 percent of the time teachers interacted with the learning-disabled child was devoted to helping with academic work, whereas this was true only 25 percent of the time with non-handicapped peers. Teachers were found to be more likely to interact with the non-learning disabled child for more assertive purposes, such as sending the child on errands, eliciting the child's aid in organizing games and helping others in non-academic matters.

Furthermore, learning-disabled children are often rejected by peers as well as by teachers and parents. When lacking necessary social skills for successful peer interaction, they resort to immature and negative behaviors to gain attention.

Some learning-disabled children have difficulty with attention and impulse control, such as restlessness and hyperactivity and often feel out of control of their actions. They frequently verbalize: "Something made me act bad. I wish I could stop it." Such behaviors interfere with adaptive academic and social functioning and result in much negative feedback from teachers and peers. When not helped to control negative behaviors and given positive attention for appropriate self-control, maladaptive patterns may develop, which these children use to obtain any kind of attention.

Thus, learning-disabled children may develop self-defeating patterns for two reasons: such behaviors provide short-term success in avoiding stressful situations or gaining control over them; or, they have no alternative coping strategies.. They need significant adults to help them *unlearn* self-defeating behavior and learn more appropriate coping strategies.

Resources To Help the Child Cope with the Stressful Life Event

Inner Resources

Actual or perceived inner resources of the individual (i.e., level of general intelligence, cognitive strengths and deficits, psychological adjustment) contribute to the level of coping with everyday and extraordinary stresses (McNamee & McNamee, 1981, p. 190). Inner resources can be channeled to the individual's benefit or detriment, depending on psychological health. A child of average intellectual potential who is well adjusted, and exhibits adequate compensatory mechanisms (i.e., who channels energy, time and effort towards working harder in areas

affected by the disability and/or redirects his/her energy toward area of strength), can accomplish more than a child of above-average intelligence channeling energies and intelligence into figuring out ways to avoid academic tasks.

External Resources

The Mediating Agent

While many persons can serve as sources of support for the child—relatives, school personnel, peers, neighbors—parents and teachers spend most time with the child (McNamee & McNamee, 1981 p. 191). While these most important adults can minimize stress and help children learn adpative coping strategies for stressful situations, they can also be the *sources* of stress; they can, unfortunately, exacerbate stress and reinforce maladaptive behaviors. These adults often need to rely on psychologists or other mental health professionals to help them recognize, understand and accept the child's disability.

Management and Treatment

Anticipatory Support Mediation. Much stress can be avoided or minimized by supportive school and home environments and preparation for potential stressful experiences (McNamee & McNamee, 1981, p. 195).

A positive, nonpressuring, emotionally supportive home and school environment can be therapeutic in both minimizing stress and helping the child build the necessary inner resources to deal more effectively with stress and anxiety, such as the child's feelings of self-worth, hope and appropriate problem-solving strategies. Such supportive climate exists in ideal educational programs for learning-disabled children: small, self-contained classes or resource rooms where a child receives extra help daily for one to three hours. In such conditions, whether in the classroom or the home, avoidance behaviors and self-defeating patterns are minimized. The supportive environment should include the following:

Opportunities for Mastery and Success

1) Individualization of instruction so that material is on the child's level;

2) Utilization of mastery teaching principles and errorless learning techniques (i.e., introducing material in small steps, distributed practice, overlearning, reduced response competition, discrimination practice) so that material may be mastered before questions are asked;

3) Breaking the goal into components and rewarding efforts at each step toward goal, including on-task behavior;

4) Setting up realistic expectations, goals; discouraging involvement in a situation for which child lacks proper skills; providing realistic vocational guidance at the high school level;

5) Teaching to the child's strengths; utilizing strengths to help the child compensate for deficits.

"Encapsulation" of the disability: delineation of the parameters of the disability (what is affected by deficit, what is not); helping children differenciate and integrate their vulnerabilities and strengths toward more realistic perceptions:

1) *Focus on areas of strength* so that a child with a language deficit, mechanically inclined and good at sports, should be encouraged and rewarded for strides in athletic areas;

2) *Lack of focus or emphasis on areas of deficit* so that children, sensitive to exposing their inadequacies to their parents (not wanting to disappoint them) might be given opportunities to do tasks with parents at which they can succeed (preferably to do homework with parents, which they usually shun).

Encouragement of chance-taking, so that a child will be able to risk failures and tolerate frustration by rewarding perserverance on difficult tasks.

Encouragement of a close positive relationship with child by:

1) responding to appropriate interactions initiated by child;

2) communicating acceptance and respect for child by lack of criticism or labeling.

Encouragement of initiative, assertiveness and independence; reward all steps toward these goals.

Help in learning appropriate behavior and unlearning inappropriate patterns:

1) set up clear-cut rules and expectations;

2) provide consistent feedback, contingent on behavior.

Help in learning self-control skills:

1) counteract impulsivity and hyperactivity by teaching children verbal self-instructional techniques (Meichenbaum, 1977);

2) help children deal appropriately with negative emotions: help child focus on and label feeling, serving to delay or diffuse response; train child to discover what events led to negative feelings; teach child alternative behavioral responses through role-playing and practice.

Encouragement of appropriate social interactions and social skills:

1) teach children to pick up and label subtle social and affective cues;

2) sensitize children to others' feelings through role-playing;

3) practice social interactions and skills: taking turns, expression of feelings, listening through role-playing.

Parents and teachers can often anticipate, prepare and support children through a stressful experience, such as children's going from a self-contained classroom to several classes in the mainstream. Some steps that may minimize and support children through the transition are:

- discussing approaching transition, familiarizing the child with the setting and teacher;
- helping the child discuss his or her feelings and fears about the transition to the mainstream;
- reassuring the child that help is available if needed;
- discussing the child's fears about the transition; describing the role-playing alternative solutions and coping mechanisms if something were to go wrong.

Responsive Support Mediation

Common stresses not always anticipated or circumvented include the adjustment and social problems learning-disabled children face in the mainstream such as isolation and rejection, stigma and derogatory labeling. Parents and teachers should be alerted to early warning signs of the child's distress so that intervention can be provided. Some methods of intervention that may be helpful are:

- being physically and verbally supportive;
- helping the child express feelings of isolation, shame and frustration, verbally or through play;
- providing the child and rest of class with information about learning disabilities to increase understanding and minimize fear and stigma;
- setting up sensitivity training experiences whereby all the children experience the feeling of being learning-disabled, done by utilizing special effects mirrors that distort perceptions, or through role playing;
- appointing the learning-disabled child as leader or monitor in areas where he or she can be successful;
- emphasizing and building the child's cognitive and social strengths and minimizing focus on deficits.

Parents and teachers often need professional guidance beyond these methods of intervention. Professionals can help with the following:

Early identification of learning disabilities. Training is needed to detect early warning signs, such as delayed developmental milestones for speech or walking, expressive or receptive language difficulty, poor handwriting, disorganization, inability to transfer from one situation to another, prevalence of reversals, confustion with concepts of left-right. When these or similar signs exist, referral should be made for a comprehensive psychoeducational evaluation.

Understanding and acceptance of the learning disability Family counseling and/or peer support groups can help parents form realistic expectations and demands and come to terms with their feelings about having a handicapped child. Parents can find help in such organizations as: the Orton Society and the Association for Children with Learning Disabilities.

Training in effective mediation skills Individually, in a family setting or in parent groups, parents can be successfully trained to be effective mediating agents for their own children. Through parent training sessions where techniques were taught by means of videotapes, handouts, role playing and application of principles to their child's behavior, the present authors found that many parents were successful in modifying their children's behavior.

Helping parents to be advocates for their children As ideal appropriate educational services and programs do not always exist, parents often have to fight to develop such programs.

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Self-Defeating Misperceptions

GUILFORD H. BARTLETT, JR.

Young children sometimes misperceive themselves and those around them in self-defeating ways. The author traces the development of self-defeating misperceptions in a young girl as she relates to an "absentee" father, an over-protective mother, a sister who seems to be good at everything and to chosen defective friends who pose no threat to her.

The practicing psychotherapist often has to work backward in order to help the client move forward. Young adults frequently display behavior patterns that are logical consequences of misperceptions of self and others that began in childhood, misperceptions frequently formed through bias or neglect exhibited by a primary child-care figure in early years.

Misperceptions can be viewed from their influence on the life style of persons perceived as normal—those having made an adequate adjustment in life—or their influence on adjustments that deviate sufficiently from societal expectations as to be labeled abnormal, seriously psychoneurotic or psychotic. We are considering here the influence of early misconceptions of self and others on an individual who from all outward manifestations is considered normal. The child in question comes from an intact family—a mother, father and younger sister, all interacting reasonably well in a loving and supportive atmosphere.

Until five or six, a young child depends almost entirely on one person, the primary child-care figure, for feeding, love, stimulation, validation and maintenance. When this figure, who may be mother, father, older sibling, baby sitter or foster parent is unable to provide at least minimally for the psychological needs of the child, neglect occurs. The child begins to assimilate the negative bias system of the primary-care figure. This bias may result from unhappiness over having to care for the child in the first place or an underlying neurotic personality structure in a person who is otherwise loving and supportive of the child.

Most clients coming for therapy are adults, many young adults. Less often do we have the chance to intervene in the misperceptions of the child. Parents are reluctant to turn their child over to a therapist unless the child's behavior is bizarre or dangerous. Even when parents reach the point of desperation, they frequently assume that if they can't help the child, no one else can either. Referral of child clients is sometimes the result of the insistence or direction of agencies outside the home—the school principal or counselor, a pediatrician, social worker or the police.

The case described here, despite its complexity, is hopeful, with a good prognosis.

Fourteen-year-old Jenny was brought to therapy by her mother after the mother found that her daughter during a summer vacation with a girl friend had been taking a variety of drugs, Valium, Seconal and marijuana. The pills were from prescribed medications one of the mothers had in her medicine cabinet; the marijuana was either purchased from street vendors or given to the girls by peers.

Jenny was shaken and confessed the drug abuse to her mother when her friend Clark, 15, was found dead in an abandoned house. He had taken Methadone and alcohol and had suffocated on his vomit after the friends he had been drinking with went home for the night.

Adlerian therapists use early recollections as a shortcut method for relating mistaken perceptions of self to the present life situation of the client. Jenny's early recollections give a picture of the degree of alienation, rejection and anxiety Jenny experiences daily. She remembers that at two and a half her mother told her she was going to a party and got her dressed. When they arrived at their destination it wasn't a party, it was the hospital. Jenny was to have her tonsils taken out. Her mother stayed with her in the hospital. Jenny's reaction: "Mommy lies to me, I can't trust her." The mother's support by staying with her in the hospital did not make up for the deceit.

At four Jenny had to go to nursery school. Every day when the bus came she cried. One day on the way to school she passed by the municipal incinerator and felt agitated and fearful. From that time she reacted with fear whenever she passed the incinerator. She perceived that no one cared about her fears or did anything to make things better.

When she was almost five Jenny's sister was born. Jenny hated her, and she told her grandmother so one day when she was sitting on her lap. When she shared these negative feelings about her younger sister, the grandmother pushed her off. Jenny's perception of this: "When you tell people how you really feel, you get rejected."

Whether these memories occurred as Jenny relates them is not important. What does matter is that they consistently show her perception of her childhood situation as being unloved and unprotected. Childhood feelings she experienced as a result were anxiousness, fearfulness, alienation and rejection, feelings well established by age five and continuing until now at 16.

Dreams shed further light on Jenny's misperceptions of herself and her inadequate adjustment to life.

Dream one (age 14 years): "My sister was very sick in the hospital (something about her tonsils). The nurse came and said, 'She's dying.' My sister had no hair. It was awful. I had to give the news to my parents. They said, 'Now you won't have to worry about her anymore.' I felt guilty, as though it was all my fault. I always feel worthless and blame

myself. Whenever something happens with my sister I usually assume I am wrong, it is my fault."

Guilt is used to feel better about oneself and to convince others that one is a good person because one feels guilty. You want others to judge you by your guilt feelings, rather than by your actions. When one hurts oneself it is always for the purpose of achieving something, in this case to enhance Jenny's status. It is as though she were saying, "See, I am really a very good person. I punish myself!"

The tendency to make big things out of little things is clear in this dream. Her resolve to kill off her rival younger sister is diminished by her squeamishness about death and her fear of being guilty. She uses feelings of guilt as a way to divert others from noticing that she had negative feelings about her sister in the first place. "Only bad people have negative feelings."

Jenny's desire to dispose of her intruding sister is clear; also clear is the ambivalence generated by Jenny's need to be perceived as a good person.

Dream two (two weeks after dream one): "This is a dream of being arrested. I was at home. My sister went out. Then the police came. They pulled out a big, big thing of angel dust. They couldn't reach my parents, so they called my grandparents. My grandparents said, 'We don't know Jenny.' I woke up feeling worthless. I am worthless. I can't stand myself!"

The theme here is betrayal. It is implied that the younger sister has left and sent the police back to arrest Jenny. When she gets caught with the goods her parents are not around to help her and her grandparents refuse to come to her aid. She is betrayed by everyone involved. She can trust no one. Naturally, she is also unjustly blamed.

Dream 3 (six weeks after dream two): "I was trying out for the Army. It was in the girls' gym at school. They told everybody who had made it. They didn't call my name. I said, 'Hey! What do you mean?' Everybody just walked away."

Here Jenny is trying to find a place for herself in life; it is noble to serve one's country, to give of oneself. But even in this attempt she is rejected. She feels worthless again. And when she tries to stand up for her rights, she is ignored.

The home situation has been complicated by the relationship between Jenny's father and the rest of the family. Mom and Dad were not getting along during Jenny's early years. Dad drank heavily and ran around with other women. He often arrived home from "work" at 8 or later, after the evening meal. There were many fights between the parents. Dad was often away on business, for weeks at a time.

Jenny didn't know much about her father, having so little contact with him. She felt rejected by him, though she had barely articulated this to anyone. She mistakenly believed that everyone else had happy, normal feelings. Other dads, she believed, took their kids to ball games

and ballet lessons and were around a lot of the time and did things with their families.

Jenny, not knowing how to respond when her young friends asked her about her father, made up stories. The one she used most was that he was dead. This got her off the hook with her playmates and got her sympathy.

She also had problems in her relationship with Mom, who herself had grown up with a mother who was critical, judgmental and demeaning. Mom, constantly told that she was not pretty, had developed the feeling that she was worthless and unattractive. She never had boyfriends and despaired of ever attracting one. When she did marry she gave up all thoughts of education and a career, focusing on areas in which she thought she might succeed, making a home for her husband and raising children. She became "devoted."

The expression of this devotion for her first-born, Jenny, was a sheltering overprotectiveness that conveyed to Jenny a view of the world as dangerous and a view of herself as unable to protect herself without the help of Mommy.

Mom's basic lack of confidence in herself gradually eroded the relationship with her husband. He, himself insecure, could not cope with her dependency and sought comfort elsewhere, the company of other women and drinking. Despite her conscious efforts not to do so, Mom passed on to Jenny her own lack of confidence.

By age eight Jenny began to think of herself as unattractive and was withdrawing in her relations with other children. She became the scapegoat of her peer group, the one anyone could pick on and put down. She clung to the company of children who behaved more confidently and was willing to take any manner of abuse in order to belong. She found that the ideas she shared with friends were presented to the group as though the friends had thought them up. Her friends made fun of her, embarrassing her in front of the group. She submitted to the treatment, developing a feeling of belonging by means of this subservient role and yet felt more worthless and detestable as time went on.

As she approached puberty, the insecurity all children experience was intensified for Jenny by the successes of her younger sister. Patty was good at school and even better at sports. During the winter Mom took Patty off to the mountains for ski tournaments—in the spring and fall to skating competitions. Jenny hated her sister for this special treatment.

By thirteen Jenny was doing poorly in school and was hanging out with the neighborhood outcasts. The older boys in this group, 16 to 18, had dropped out of school, worked during the day at menial jobs and at night hung out near a local store, smoking pot, drinking beer and dabbling in sex. The younger ones went to school, took pride in their poor academic functioning and hoped someday to be as "cool" as their older role models. Jenny was afraid of sex, but was interested in drugs.

Fear of sex relates to her mistrust of intimacy, a state Jenny feels is paired with sexual relations. Intimacy is equated with a loss of control, whereas drugs can be more easily controlled and are safer (a complex misperception).

Her best friend Sue is helpful in this regard. Sue's parents are divorced and she lives with her mother, an actress who is seldom home.

Jenny admires Sue, who she feels is confident and a lot of fun. She does outrageous things. She dresses in high "punk" style; she attends concerts of the most extreme punk rock groups; she has intercourse with strangers, just for kicks.

Jenny follows Sue about in awe of her, living vicariously through Sue's experiences. Only much later does Jenny begin to realize that Sue has few ideas of her own and, in fact, often gets her ideas from Jenny.

Sue offered Jenny some pills she had taken from her mother's medicine cabinet. In accepting the pills, Jenny felt closer to her friend, more like her; she felt liked and accepted by another.

By now we have a fairly clear picture of the impact Jenny's mistaken and self-defeating perceptions of herself and others were having on her life in her thirteenth year. Under the best of circumstances, thirteen is rough. It is hard to be confident about positive values, to have the courage to stand up for what one believes is right, to feel good about oneself.

In Jenny's case, she was handicapped by her poor self-image and mistaken perceptions of self and others, which included: (1) "My sister is good at everything, and because of this gets more attention from my parents." Little does Jenny know that her sister works very hard to catch up with her, and in fact admires and respects her big sister. Also, the parents really spend more time on Jenny than on her sister, feeling Jenny needs them more. The perceptual bias Jenny developed earlier prevails. (2) "I am ugly; my nose is too big, my legs are too skinny; my body is unattractive." In reality she is very pretty, her nose is not too big, she has nicely shaped legs and an excellent figure. (3) "I am not a likeable person; people always use me; boys are not attracted to me." Actually, Jenny meets people easily when she allows herself to do so. She has a ready smile, expresses herself well, cares about people—a positive basic value often concealed by her fears and need to protect herself from the perceived abuse of others. She does not often exert the effort to make new friends, assuming that it won't work, so why try. She goes to great lengths to be unattractive to boys, wearing clothes that cover up and conceal the body she loathes. When a boy shows interest in her she runs the other way. She fears intimacy, fearing the loss of control she associates with sex. The fear and assumption probably derive from the model of sexual relationships Jenny has observed in her parents; she uses her mother's dependent attitude on Dad to avoid responsibility for herself, which she is sure she cannot handle.

Jenny rejects boys who are responsible and show an interest in getting to know her; rather, she is attracted to immature boys who in appearance could pass for girls, who use drugs and show no interest in forming relationships. This preference keeps Jenny firmly in control, protects her from being a woman like Mom.

(4) "Doing well in school is just too much work, so why bother!" Jenny did poorly in eighth grade at a good public school; her parents correctly recognized the influence of the peer group in this, the dropout mentality. At this point Jenny was on a track to end up being untrained and financially dependent on men, like Mom. Her mistaken goal of superiority includes avoiding responsibility for her actions, while really dominating those who become involved with her.

In ninth grade her parents placed her in a private school, where her grades immediately went up. In this school Jenny took two pills from a girlfriend, not knowing what they were, but swallowing them anyway. She and the friend were observed behaving strangely, were questioned and both expelled.

Jenny will go to almost any length to maintain a positive self-image, with a strong belief that everybody has to be important. She is now at another private school, in honors classes in all subjects. While she is convinced that she will not make the same mistakes again, her therapist and parents survive on the hope that school success will become more important for Jenny than the temporary escape provided by drugs.

(5) "Life is so miserable at home and at school; the only way I can feel better is to take drugs." Jenny is fascinated by heroin, the ultimate escape. So far she has not taken it, but has added cocaine and Quaaludes, preferring the latter which she takes when she is alone at home and with friends on week ends.

(6) "If I carefully avoid taking responsibility for anything I do, nothing bad can happen to me, or at least if it does I won't have to take the blame for it. If I take charge of my life, I will undoubtedly make a mess of it." This is the core of Jenny's misperceptions of herself and results in her consistent flight from responsibility.

Jenny has now been in therapy for two and a half years. She clings to her misconceived view of herself, others and the world around her, convinced that her self-view is the only thing that makes sense of her experiences and feelings. Nevertheless, she is responding slowly to the therapy; she does well in school, is forming a few solid friendships and understands her actions better.

The prognosis is guarded but hopeful. The key to Jenny's growth in true self-esteem lies in the difference between herself and her sister. Her sister seems to be good at everything. As long as Jenny believes in the sister's superior self-confidence she can exult over her sister by being bad. Jenny needs an area where she can function well, better than her sister. Only then will her self-esteem increase and she will no longer have to be bad.

Children's Response to Hospitalization

LINDA ARGIRY ROUCK

A hospitalized child's illness, injury or disability contributes to physical and emotional stress, which is compounded if impaired functioning, mutilation or disfigurement result; and further compounded by separation from family, restriction of activity and play, misinterpretation of the reason for hospitalization and fear of diagnosis and treatment.

Some of the nearly four million children under 15 years hospitalized annually for physical illness, injury or disability may experience repeated hospitalizations and thus spend a major part of their lives in hospitals. The nature of the child's illness, injury or disability and its severity and bodily locus contribute to physical and emotional stress, the latter compounded if impaired functioning, mutilation or disfigurement results. Hospitalization contributes additional stress when associated with separation from parents or parent surrogates; restriction of physical mobility or play; misinterpretation of the separation as punishment or abandonment; and fear of diagnostic and treatment procedures.

For some children, adverse effects of hospitalization are temporary, although some post-hospitalization regressive behavior and manipulative testing of parents occur. For others, adverse effects can be long-lasting and could result in adult dysfunction. Children from 6 months to 6 years are especially at risk, because developmental processes imperative for mental health may be disrupted, such as attachment in infancy to at least one continuing, nurturing caretaker. Equally vulnerable are children with pre-existing emotional problems, whose socialization already has been impaired and is now further disrupted.

Such chronic and life-threatening conditions as juvenile diabetes, hemophilia or childhood malignancies have a profound and pervasive impact on children and their families. Even in these conditions the effects for child and family depend on many mediating factors, stability and quality of family life; attitudes of parents toward illness and bodily impairment; and the meaning the child ascribes to separation from family, to symptoms and to diagnostic and surgical procedures.

In discussing some of the adverse effects of hospitalization for children and reviewing preventive methods that have become a part of enlightened pediatric services in this country and abroad, we note here that, as with response to any of the life crises, stress of hospitalization is not inevitably an occasion for regression or arrested development, but may be associated with significant growth and realization of potential.

At a minimum, the experience of hospitalization shapes attitudes toward hospitals and the health professions. These attitudes, like many others acquired in the formative years, are difficult to alter in adult life and, if negative, may result in reluctance to seek diagnosis and treatment for potentially serious health problems in the adult years.

Developmental Level and the Effects of Hospitalization

Study of the effects of hospitalization focused initially on children deprived of the opportunity to form an attachment to a parental caretaker or who, having already formed an attachment, were separated from parents. Institutionalized children who had not experienced parental loving care often failed to thrive and showed delays in physical, cognitive and emotional development as compared to non-institutionalized agemates (see, e.g., a study of children in a Teheran orphanage, Dennis and Najarian, 1957). Such terms as "hospitalism" and "maternal deprivation" were used to describe these effects, which at first were thought to be irreversible. Now it is recognized that reduction of sensory stimulation ("sensory deprivation") contributed to delayed or arrested development and that enrichment of the environment could reverse the process. The quality of institutionalization for very young children began to change with increasing recognition of the importance of loving caretakers who would handle, cuddle, talk and sing to the child.

Another investigation focused on hospitalization for medical and surgical care for periods of a few days to more than a year. Robertson (1958) and Bowlby (1969) described the child's response to hospitalization and separation from mother (or person to whom the child is attached) as occurring in three phases: protest, despair and denial. For denial Bowlby prefers the term "detachment" as a natural counterpart to attachment (1969, p. 29). On separation, the child is initially distraught, then grieving and angry and, if the separation is long enough, represses longing for the mother, lacking the cognitive and emotional resources to cope otherwise with the experience. During the detachment phases the child seemingly has settled in and appears to be adapting well to the separation. The child may no longer cry when the mother leaves. In the post-hospitalization period, however, further impact may show in such regressive behavior as excessive clinging, wishing to sleep with parents at night, lapses in bladder and bowel control, lowered frustration tolerance as expressed in temper tantrums and crying. Self-destructive behavior may appear, such as accident proneness, picking at skin or pulling hair or repetitive head-banging.

Separation is a developmental task that must be accomplished in order to cope with normal leave-taking of everyday life. Good parenting, however, provides graded separation experience with preparation of the child by gradual introduction of surrogates and without deception, that is, without promise of momentary return when the absence

may be for hours or days. Such deception during hospitalization may engender not only a sense of uncertainty and abandonment but hostility toward the parent describes the experience of Laura in Robertson's classic film *A Two-Year-Old Goes to Hospital* (1953).

Table 1

Laura's Eight Days in a British Hospital*

Days 1 and 2: Laura, at the age of two years and five months, is hospitalized for repair of an umbilical hernia. Upon meeting the admitting nurse, Laura is cheerful and unafraid but screams for her mother when taken away. While she is given a bath and a temperature is recorded, her mother is in the waiting room. Laura has unusual control for her age over emotional expression and periodically becomes seemingly calm. When mother comes in to say goodbye, Laura sobs at first, then becomes solemn and apprehensive. Mother leaves with Laura a piece of blanket the child calls her "baby"; this and her teddy bear are sources of comfort for Laura as her ordeal progresses. The next morning she inquires plaintively of the nurses who pass where her mother has gone. She responds slowly to the nurse who comes to play and pushes away a proffered toy. After surgery when her parents visit, Laura reaches for her mother but is restrained by the nurse, who is concerned about the child's stitches. Laura turns away from her parents and covers her eyes. She is subdued and perplexed when her parents leave.

Days 3 and 4: When the nurse comes to play, Laura goes through a cycle of initial withdrawal, weeping and regaining of composure. She seems to have settled down. She makes no attempt to reach her mother at the next visit, but gradually she becomes more animated and now smiles. At her mother's departure she turns her head away again. She forbids the nurse to remove the chair on which her mother had been sitting.

Days 5 through 7: When mother returns Laura, now increasingly withdrawn, turns her head and wipes off her mother's kiss. She becomes subdued and unresponsive when mother visits again but gives father a warmer welcome. When a newly admitted child cries, Laura says with urgency, "Why is that boy crying? Go fetch his mummy."

Day 8: On the last day Laura watches, cautious and unsmiling, as if reluctant to trust her mother's words that she is going home. Only when her shoes are produced does she begin to dress eagerly and to collect every one of her personal possessions.

At Home: Laura went through a period of anxiety and irritability. She would cling to her mother, but she was also suddenly aggressive, punching and scratching her mother. At first she had difficulty sleeping and called out several times in her sleep, "Don't do it to me. I'm not a naughty girl." These behaviors gradually diminished. Six months later Laura got a reminder of the hospital and burst into tears. She said angrily to her mother, "Where was you all that time?" She turned away from her mother and wept on father's shoulder. Mother said in dismay, "She seems to blame me for something."

When illness, injury or disability prolong hospitalization, emerging cognitive, social emotional and physical development may be seriously disrupted. Erikson (1963), who conceptualizes emotional development in stages, sees the acquiring of a sense of trust as prerequisite to the development of hope and an optimistic outlook on life. Autonomy, initiative and a sense of competence develop with emerging controls over body functions, increasing facility in interpersonal relationships beyond the family and mastery of school tasks. At adolescence the

*Abstracted and paraphrased in part by the present author from a description of the film produced by James Robertson and described in his book, *Young Children in Hospitals*, 1958, pp. 33-42.

development of ego identity peaks and social, sexual and occupational explorations occur that are vital to the crystallization of the sense of identity and a value system.

If at any of these periods prolonged pain, restricted mobility, deprivation of peer relationships, interrupted schooling and perhaps the additional burden of disfigurement occur, development will be affected, although not always adversely. Children may begin to misperceive themselves as stigmatized, unworthy and unable to cope. Trends towards passivity, seclusion and avoidance of risk-taking ensue, through which the child safeguards self-esteem against the threat of failure or rejection. Although these solutions reduce anxiety, they encourage evasion of opportunities for reality testing of these misconceptions. Parents may also unwittingly contribute to dependence and erosion of self-esteem by inhibiting opportunity for appropriate part-time jobs, participation in sports or acquisition of appropriate social and sexual experience.

Change of Body Image as a Source of Stress

Amputations, mutilations or disfigurements from injury or surgery in malignancies or accidents involve abrupt changes in schema and body image stressful to child and family. The body schema is a psychological representation of the location and position of parts of the body in space. The construct, body image, includes a value component acquired in the formative years from cultural and family expectancies that underlie attitudes toward types of body build and conceptions of physical beauty and grace.

Some evidence suggests that the child under five has a poorly developed body schema, while that of an adolescent is more highly integrated. These differences in developmental level affect response to bodily changes. The child under five may not experience phantom sensations from a missing limb following amputation, while the adolescent may experience the phenomenon (Simmel, 1962). Similarly, the younger child may accommodate more easily to a prosthesis, while the adolescent concerned with acceptance of the physical self by peers may have greater difficulty adapting to the loss and accepting the prosthesis. Moreover, bodily intactness, optimal functioning and the illusion of absolute health are so overvalued in our society that observable dysfunctions contribute to the child's loss of self-esteem.

Children with severe body burns are particularly vulnerable to emotional problems (Long & Cope, 1961). Their body image becomes increasingly distorted as they observe their wounds daily during debridement and experience fixation of body parts for skin grafts (Herren & Crawford, 1970). Even after skin coverage is complete, the distorted body image may persist and affect the child's return to normal social activities.

Mourning Body Losses

In loss of body parts or functioning, a pattern not unlike that observed in bereavement may ensue, which complicates and extends the process of adapting. Parents and children may progress through or oscillate between periods of shock and disbelief, feeling anger with primary health caretakers and depression that derives from a sense of helplessness and erosion of hope. Eventually, when both parents and child can accept reality, the child moves toward perception of self as able to cope and accepts the necessary aids for adaptation such as prostheses, wheelchair or special diet.

Emotional disturbances persisting in some children may be a function of pre-existing emotional problems exacerbated by the additional stress of illness and hospitalization. Regressive, aggressive and guilt reactions may persist even in previously well-adjusted children who experience severe stress of the daily treatment of burns (Long & Cope, 1961). Understanding and acceptance of these behaviors as indices of distress can help both parents and professional staff refrain from moral judgments about the behavior, especially of the older child or adolescent of whom greater self-control is often expected under stress.

Prevention and Amelioration

Provision of facilities appropriate to the special needs of children, keeping them as close as possible within their normal social setting is the goal of advocates of children's rights (Berlin, 1975), a goal that can be met by humanizing hospital care and adjunct services, providing anticipatory preparation of children and parents and therapeutic intervention when indicated. While children's hospitals and pediatric services in medical centers have incorporated preventitive ameliorative practices, general hospitals have been slow to adopt these changes (Prugh & Jordan, 1975).

The following principles and practices are generally recommended by investigators (see, for example, Shore & Goldston, 1978).

1. Hospitalization should be avoided if possible and alternatives explored, such as home care or day hospital service that maintain the child in the normal social setting.

2. When hospitalization is necessary, it should be as brief as possible and preceded by anticipatory guidance for child and family, the preparation accomplished through play techniques with young children.

3. Provision for parental continuity of support should be made through rooming-in facilities for parents and unrestricted visiting hours for parents and siblings.

4. Architectural modification of hospitals may be necessary to provide rooming-in facilities for parents and space allocation for parental group discussions and social activities.

5. Educational facilities should be available to compensate for interrupted formal schooling, including closed circuit TV and other technological aids. Anticipatory preparation for hospitalization should become part of formal schooling and include a tour of the local hospital.

Table 2 below lists some alternatives to hospitalization and recommended practices of pediatric services, focusing on two aspects of preparation: anticipatory guidance and therapy with families and play techniques with children. When hospitalization is not immediate, preparation can begin at home and continue into the hospital where programs have been developed for each age level from infancy through adolescence in centers that have incorporated the above guidelines. For the adolescent, preparation should begin with a pediatrician who can answer questions about possible body losses and their effect on sexuality and appearance. Plank (1962) has used drawings even with younger children to show anatomical parts affected.

Table 2

Innovations in the Hospitalization of Children and Adolescents*

Some Alternatives to Hospitalization
—*Night hospital:* Treatments like dialysis can be accomplished while the child sleeps; child returns to normal home life during the day.
—*Day hospital:* Treatments can be given during the day; the child returns home to spend the evening and to sleep.
—*Hotels and motels:* Mother and child stay in the vicinity of the hospital while diagnostic procedures are under way.
—*Rehabilitation centers:* Diagnostic and treatment procedures are centralized in one unit for children with multiple disabilities.
—*Home care:* Medical and nursing personnel make house calls and provide diagnostic and treatment procedures in the home.
Some Features of the Optimum Hospital Environment
—*Rooming-in:* Parents can room in with the child and assist with treatments and nursing care of the child.
—*Unrestricted visiting hours:* Parents and siblings can visit freely; limits set by the needs of the child and not traditional hospital policy.
—*Child care services:* Hospital provides supervision for younger siblings when parents cannot arrange for care of children at home during visits.
—*Anticipatory guidance and therapy:* Hospital staff offer guidance to parents for preparation of the child for hospitalization and return of the child to the home. Individual and family therapy may become part of the child's treatment plan when indicated.
—*Play rooms:* Hospital provides equipment for age-appropriate play and play therapy, such as a play hospital for simulating medical and surgical procedures.
—*Educational facilities:* Hospital provides services of teachers at bedside or through closed circuit TV; program coordinated with child's home school curriculum.
—*Communication aid across language barriers:* Hospital provides interpreters and/or bilingual caretakers.
—*Post-hospital follow-up:* Hospital staff make home visits for observation of progress and planning help for emotional sequelae.

*See References for description of modalities and findings about their use as reported in the literature.

Play Techniques

Play is an important adjunct in preparation of children for hospitalization and in providing therapy. It is often said that play is child's work (see, for example, Jolly, 1969). Through play the child experiences sensory stimulation vital to perceptual-motor, cognitive and emotional growth. By role-playing activities of family members, children can express feelings that cannot yet be articulated freely and in so doing ventilate anger and master fears.

At home and in school, parents and teachers can use toy medical and nursing kits and children's books about admission to the hospital to familiarize children with materials and procedures. Some hospitals provide experience with a play hospital and authentic hospital equipment (Adams, 1976) for administering anesthesia, performing surgery or viewing x-rays. Familiarity with such accoutrements helps to dispel mystery and fears. Dolls and puppets representing children and parents, nurses and doctors are used in role-reversals through which children strive for mastery or express anger for pain and discomfort of diagnostic and treatment procedures.

Anticipatory Guidance and Therapy with Families

Family response to illness in children is exemplified in two case studies reported by Garner and Thompson (1978) for two school-age boys with juvenile diabetes.

Case 1: The boy seemed frightened in interview; parents, tense and uneasy, described the boy as "not spoiled" but having more attention than the other children. Mother handled insulin injections exclusively as father was phobic about blood. They viewed child's diabetes as the "worst thing that ever happened to us." Mother was already concerned about child's adolescence and the hereditary factor.

Case 2: Child was at ease in interview. He was active in a 4-H program, went to camp, played trumpet in the school band and gave talks after school on diabetes. Parents took turns administering insulin. Family had traveled with the child, camping in Mexico, and reported no special problems with urine testing, injections and special diet. The family did not feel the child's diabetes had affected them adversely.

Immediately after parents are informed of a child's serious or life-threatening illness, therapeutic intervention may be indicated, for shock and self-blame are acute at this time, particularly in conditions with a genetic component. Later, parents may be referred to self-help organizations and professional agencies that provide family assistance and support research for specific diseases, such as cystic fibrosis, muscular dystrophy or allergy. Help from such groups alleviates the family's sense of isolation and impending catastrophe. The sense of helplessness diminishes, and fantasies of cures are tempered by reality testing.

The healthy child with a short-term illness or repair of accidental injury may not be hospitalized long enough to learn ways of using illness for secondary gain. The chronically ill child, however, is at greater risk in learning ways of circumventing responsibility for essential life tasks. Some parents tolerate regressive behavior in hospitalized children long after more age-appropriate behavior can be resumed.

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Coping with Death: Early Childhood Experiences

ESSTOYA WHITLEY AND RUTH DUNCAN

Children experience death and speak of their sorrow, love and caring for missing persons. This article has strategies for helping children in the classroom cope with death, a natural and normal part of life, in an atmosphere that evokes open and honest discussion of death and dying.

After reading condolence letters and notes written by our 6-, 7- and 8-year-old pupils to a family whose 7-month-old son had died, we found we were struggling to write our own note of sympathy. We were doing the opposite of what we had tried to help the children do. We had used the term "loss" rather than "death." We had struggled against putting down exact words.

Children were saying exactly what they mean — speaking of sorrow and caring. They were talking about *missing* the person who had died. After rereading some of the children's letters we found it easier to put true feelings on paper. We had learned from them and wrote:

> Dear Friends,
>
> I am sorry that James died. He was such a pretty baby. We enjoyed seeing him at school. Thank you for bringing him to visit us. I know you will miss the baby. I wish that we could share the grief with you. Please come visit with us in the classroom.
>
> Love you,
> Toy (Esstoya, the co-author)

Our interest in early childhood death education came about in an unexpected but natural way. For some time we had fostered an on-going relationship between the 6-, 7- and 8-year-olds and residents of a nearby nursing home, where the average age is 85. "Adoption" of these elderly persons led us inevitably to coping with death and having to assume the responsibility of the consequences for the children.

The first year, beginning in September, we had visited "Grandma" each week. The visit before Thanksgiving was delightful. "Grandma" talked about the Halloween party we had shared with her, when we sang the songs she requested and played games. The visit ended with the usual hugs and goodbyes. During the night "Grandma" died.

With heavy anxiety we broke the news to the children the next day; it was best, we thought, to come right out and say it: "Grandma died last night." The discussion that followed was tearful, beginning with statements of regret: "They will put her into the ground. We will never see her again." Regret gave way to reflection and remembering. "Is it like sleeping forever?" "We will miss her." "She was really a good Grandma." "I wish that yesterday could have lasted forever."

Then from reflection to reality: "She lived a long time." "Her heart stopped beating." "Everyone is going to die sometime." "She was part of our family." (Adapted from Whitley, 1976, p. 78.)

Each child wrote a letter to the generic nursing-home family. The response was: "Letters from the adopted children helped more than anything else."

Realizing that hers would not be the last death, we started searching for books that might help children encounter other deaths.

Here may we pose a caution to both parents and teachers: check to see if a book really fits a situation. Some parts of a book could produce anxiety unless certain sections are modified (requiring advanced planning to modify or delete).

Development of Ideas About Death

We do not know when a child's concept of death begins. Many feel there is some awareness as early as age two. Nagy's study in 1948 (Nagy, 1959) of children's development of awareness indicates that recognition of the finality of death occurs somewhere between 5 and 9; however, until age 9 they believe that somehow death can be eluded, outwitted.

Kastenbaum (1974, p. 11) states, ". . . most children have a variety of death-related thoughts and experiences that are central to their personality development." He further emphasizes, ". . . we do not understand a child's core process of cognitive and personality development without also understanding how he or she is progressing in the discovery and integration of death (1974, p. 13). Any adult observing children will find them referring to death in play and conversation. We hear, "Bang! bang! You're dead!" and are disturbed. Enigmatically, we permit children to view graphic death portrayals on movies and television — barroom brawls and gangland murders, war and starvation.

With the dead and dying everywhere in plain view, it seems ludicrous for adults to attempt to shield children from the realities of death. In doing so, we may very well be fostering an "outer," superficial, indifferent attitude toward death. This result seems to be desensitizing and, ultimately, even dehumanizing if children are left with the problem of processing death-related events without the "skills of emotional management" necessary to psychological health (Bettelheim, 1969, p. 73).

The truth is that: "Most children have never even seen a dying or dead person since people seldom die at home these days. Following death, the body is taken from the hospital to the funeral home or to the cemetery. Children, shielded from the mourning, are frequently sent away to visit a few days with those less directly affected. Upon returning to the scene, children miss the loved one and often wait for his or her return. Hence, ignorance, mystery, and myth are perpetuated (Whitley, 1976, p. 77)."

The cycle causing adults to be unwilling or unable to cope with the realities of death continues as our "repressive outlook" is passed on to our children.

Program Objectives

Our one broad objective for a program for death education for young children is to assist them in their development of ideas and feelings about death and dying, which means primarily instilling in children a view of death as a natural, normal part of life.

Opportunities occur to promote the objectives through real life experiences: pets die; plants and birds and insects die; in newspapers and on television deaths are both reported and depicted; yes, people you know and love die. Of course, finding the resident classroom goldfish floating upside down one morning is infinitely different from learning that a child's grandparent or a schoolmate has died. Although death of a human being must unquestionably be treated as a matter of greater significance, the universality of the life cycle experience helps maintain continuity to the study of the process.

Grandma Howard, another of the nursing-home residents, was a special "grandma" for nine years during which she taught us many things. Sharing her experiences of 50 years of teaching showered us with bits of her knowledge and wisdom. We had celebrated all her birthdays, beginning with the ninety-second and were waiting the hundredth with great anticipation. In the closing months of her hundredth year she became ill. We were all pulling for her to make the hundredth, and she did. We think she saw the hundred roses and "hundred penny" box her adopted grandchildren presented. We continued our daily visits; two weeks later Grandma died.

Though school was out by that time, ten of her adopted grandchildren chose to go to the funeral forty miles away. All chose to look at her body in the coffin; most touched her. They wanted to know what a dead person feels like. Afterwards, they discussed the experience:

"Grandma looks really pretty." "She looks better than she did the day she died." "Why did they put glasses on her? She is dead and can't see." "Does the church own the coffin?" "Would the church be this pretty if Grandma wasn't here?" "I'm glad I could come and celebrate." "She had such a long life and loved us so much." "How did they put the color back in her face?" "I'm glad I could come to the funeral." "I'd like to die of old age." "I'd like to have the experience and see what it is like to die, but I'd want to come back." "I cried some just because we will not see her again."

Program Directions—Allowing Grief

"The school promotes a shameless hypocrisy when it parades a uniformly pleasant—and often false—representation of life. We must grant the child's fundamental right to learn about his real world, pleasant or not. We must treat human emotions in an honest way, for the reality of a child's world is heavily involved in emotion. There does not seem to be any authentic reason why children in school cannot learn about emotions and develop the skills of managing their own emotional life. Mastery that is born out of understanding is our greatest hope (and most effective means) for dealing with problems." (Bettleheim, 1969, p. 80)

Grief is a normal reaction to loss. Even when a favorite plant succumbs to overwatering or neglect we feel some regret, perhaps even sorrow. To be mentally healthy, we must find appropriate ways to express grief as well as love and joy.

It is all right to cry when we are hurt, sad or lonely; it is also all right to cry when a significant other dies. We may even feel angry and frustrated because we cannot restore to life that which has died.

Literature is a door through which children may share their feelings openly and reflect on examples of supportive behaviors, whether they are expressing grief or joy. Can a teacher reading *Charlotte's Web* to children fail to be moved to shed tears along with the children? Even after reading it for more than 25 years? Children need to know that big people cry too.

Each handles grief in a different manner, but nothing seems to take the place of a big lap, a soft shoulder or a good ear. To most children such a reception says, "I know how you feel and I care." More important, talking feelings out openly is essential in helping children deal with the reality instead of retreating into make-believe, expecting the loved one to return.

Role-playing is useful, along with recollections of pleasant times, looking at photographs and acknowledging that everyone will miss the loved one.

Avoidance Terminology

Death, coffin and funeral are emotionally charged words. In our society we substitute less trauma-producing words and phrases such as "passed away," "gone to rest," "gone to Heaven," "God needed him (or her)." For children well-meaning adults deliver a message that something mysterious is going on — something must be wrong — by excluding them. Even when the death of a person significant in a child's life occurs, we evade encounters with the child, reluctant to stimulate emotions within the child or, perhaps more honestly, within ourselves.

As Feifel (1974, p. 7) notes, however: "Our socially repressive outlook tends to encourage neurotic anxieties about death." A former education student of ours, whose grandmother died when the student was in second grade, said that she would feel better even today had she been allowed to see her grandmother and go to the funeral.

When you die, you're dead. Try saying that word, DEAD. It is a hard word to say, isn't it? Not hard to pronounce really, but hard to make yourself say. Maybe because it's a sad word — even a little frightening. Let's say it again! DEAD. Now let's say another word. DIE. That's what happened to Grandfather. Grandfather died. He is dead.

Thus, Grollman (1976) in *Talking About Death: A Dialogue Between Parent and Child* emphasizes using precision in choosing words to talk about death. The "avoidance" terminology like *gone to rest, passed away,*

has gone to sleep for a long time, as we are accustomed to saying, serves only to perpetuate the myths and confusion about death.

We bring our flowers and we hear lovely music, but not even flowers and music can make a tomb a place of cheer. And death makes us afraid. We feel so helpless and alone (Allen, 1979, p. 27).

Some Cautions

It is important to orientate the parents if "death study" is to be included in the curriculum. Even adults who favor death education in general are sometimes shocked by the idea of engaging young children in activities focusing attention on death. Childhood, they argue, is a time to enjoy just being a child. Yet studies indicate that ". . . the child's fundamental construction of reality involves working with the challenging questions of directionality, finality limits and separation — death related problems, all" (Kastenbaum, 1974, p. 13). Parents need to know this, recognizing that "Children never live in a world apart from death" (Kastenbaum, 1974, p. 13).

A second caution is to provide a climate in which children feel free to talk about whatever bothers them.

A third caution is to recognize that no one knows all the answers. The classroom teachers who encourage free discussion must be prepared for many different questions and points of view about both the physical and the metaphysical aspects of death. "Why did she die?" may be relatively simple to explain medically. "Grandma was over one hundred. The body just wears out." An entire unit on the life cycle may thus be initiated. Metaphysically, the "why" is not one for which anyone can have a knowing answer, although many points of view may be expressed, and no one is to be criticized for an honestly held position.

A fourth caution relates to the teacher's position, in which the teacher is cautioned not to impose personal beliefs or values in leading discussions about death. The line between helping students learn and proselytizing is thin and must never be crossed. It is important to be able to say, "I'm not sure, I do not know. I wonder about that too, so let's think about it together."

A Final Word

The many books on death and dying published in the last 15 years are evidence of our desire to learn better ways to cope with death. Courses on death are taught in many colleges and even some high schools. Institutions dedicated solely to the study of death have sprung up, and television programs dealing with the subject are not uncommon.

To change some of our attitudes is the purpose of our program in death education. Ultimately, we may overcome our fear, ignorance and inability or unwillingness to express our feelings about death and treat it as the natural component of the life cycle that it is.

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Helping Children Cope with Divorce

ABIGAIL S. MCNAMEE

Three stages of divorce that present unique stress factors for a child are described, as well as children's perceptions and reactions to each stage. The author emphasizes strategies to be used by parents in the home and teachers in the classroom.

Lee, a 3-year-old, lined up many of her dolls and teddy bears in order, naming each: "Daddy, Mommy, Lee, John and Todd (brothers), Pat (stepmother), Janey and Nan (step-sisters), Boopie (dog) and Scooter (cat)." She then separated her line into two "family" clusters: Daddy, Pat, Todd, Janey, Nan; and Mommy, John, Lee, Boopie, Scooter. Finally she re-arranged her families as they were first lined up. She asked, "Why can't we all live with Daddy? He wouldn't mind." In attempting to cope with her parents' divorce, Lee was trying to understand, through play, what had happened to her family; she arranged in fantasy what she could not arrange in reality. Nine years later she continues to cope with their divorce as she yells at her step-father, "You're not my father!"

Coping with the divorce of one's parents is a long (perhaps life-long), hard-going process. Albert Solnit, Director of the Yale Child Study Center in New Haven, Connecticut, says "Divorce is one of the most serious and complex mental health crises facing children of the 80's." (*Newsweek*, February 11, 1980). The children with whom we live and work will need help with this crisis, help that involves the meeting of immediate needs and the building of resources against which the child can draw so that he or she can grow toward feelings of self-worth, self-confidence and hope rather than worthlessness, helplessness and hopelessness.

Sula Wolff (1969, p. xiii) writes that the help provided for children under stress fulfills the double purpose of relieving present anxieties and preventing personality defects later in life. Five stages of the divorce process present unique stress factors for a child: 1) family discord, 2) family separation and divorce, 3) single-parent household, 4) step-parent household, 5) step- and half-siblings in the household. Discussed here will be the first three stages in terms of stress factors related to the stage, children's perceptions and reactions and strategies for helping children cope in the home and school setting.

Stage One: Family Discord

Stress Factors Louise Despert writes: ". . . divorce is not the costliest experience possible to a child. Unhappy marriage without divorce . . .

emotional divorce . . . can be far more destructive to him than divorce" (1962, p. 2). Emotional divorce is that time when the relationship between parents is tense and discordant most of the time. One or both parents may feel apathetic, not caring for the other any longer, with silences and empty courtesies covering disappointment and hatred (p. 9). They may also feel antagonistic, creating a hostile and disorganized household with argument and physical fighting an every-day occurrence. A child is often expected to side with one parent; often, too, a child becomes the hated reason that the parents have remained together.

While in many marriages there is occasional discord in an overall pattern of loving, here we consider those where the pattern of discord is predominant, "even though legal divorce may never be considered" (Despert, p. 7). For some parents, this period of emotional divorce becomes the chronic relationship and continues without change for many reasons: children, finances, convenience, fear, exhaustion and even pessimism about their chances of forming another, better relationship (Steinzor, 1969, p. 18).

Children's Perceptions and Reactions Many parents think their child is unaware of the tension; they delude themselves that they have maintained a calm front before the child, avoiding argument or waiting to quarrel until the child is asleep. Children, however, are quite resourceful in finding ways to overhear parent conversations as they listen at the bedroom door or to telephone conversations. Eavesdropping is made easy when parents assume children can't hear or understand or are not interested in adult talk. When children hear their parents argue and see their antagonism, they feel their own powerlessness and lack of control.

Despert describes the suffering of older children when the divorce is emotional: divided loyalties, shaken security, anxiety about the uncertain and unexpressed, unclarified confusions, fear not explained away. "The unclarified situation between his parents is far more threatening to a child than a realistic situation, however painful, which is squarely faced by his parents" (p. 9). A third grader said, "I go to my room when my parents argue because I'm afraid." Young children know their parents' relationship closely affects their own future: "What will happen to me?" They know they are small and in need of care and protection. The fear of abandonment by one or both parents is overpowering as they live with discord and conclude that divorce will take place.

Children often feel guilty when discord becomes the pattern of family life, fearing they might have caused the problem between the parents. A child might think, "What did I do to make Mommy so mad at Daddy?" or "If only I was good enough, maybe Mommy and Daddy wouldn't fight." Children sometimes divert the parents' anger toward them by becoming discipline problems, easing the parental friction and uniting the parents, even if against the child. Children often become ill to

control unhappy families, bringing members together in the common cause of helping the family member who is sick.

The cost of continuing a discordant marriage can be too great in child stress. A child experiencing the stress of the family's emotional divorce can become increasingly abusive toward others — adults, siblings and friends — or depressed and withdrawn. Even a very young child is responsive to the feelings of parents. A parent in a discordant marriage is likely to handle an infant differently, with distraction or roughness as the child is picked up, changed and fed, or with neglect as the child may be left to cry longer in the crib or playpen. A baby handled in these ways will soon become unhappy and anxious, crying or moaning, losing interest in persons and toys.

Strategies for Helping Children Cope It is crucial that a child experience some relief from feelings of anxiety, fear and guilt. He or she can be told, "Mommy and Daddy get angry with each other, but you are not making us angry. You don't make us fight." The parent taking out anger on the child can apologize, saying something like: "I'm sorry. When I get angry with Daddy (Mommy) I start to holler at everybody, even you. I don't mean to. I'm angry with Daddy (Mommy), not with you." A child needs to be reassured that he or she is not to blame, is loved and will be taken care of despite parental discord. It is a mistake to avoid an issue or lie to a child. It may be that another family member (or someone outside the family) can help in explaining what is going on and in offering reassurance to the child, but the most persuasive explanation and reassurance will be that of the parent.

Non-verbal warmth (cuddling, touching, stroking and holding) is also important during times of family discord. Words alone are never enough and are largely ineffectual with the youngest children. Playthings too are helpful in that a child can *play* about what he or she cannot express verbally: with dolls and stuffed or rubber animals, doll house equipment, cars and trucks, puppets, sand and water. A child can use any of these materials at home and at school to replicate what has been experienced.

Stage Two: Family Separation and Divorce

Stress Factors Many parents find the actual separation or divorce "an unfamiliar and threatening world that they are totally unprepared for. Suddenly they are alone with no one to praise or blame, no one to be insecure with, no one to share or hide from" (Krantzler, 1973, p. 42). Adjustments seem to be required in all directions at once: the children seem out of control, eating alone with the children seems unbearable, haggling continues over money, child support and visitation rights.

Some parents, however, feel the separation as a relief with the hostile, disruptive environment eased. There is time to think: "How can I survive? How can I be happy? How can I help my children?" Divorce

need not be a destructive experience; it can be a cleansing and healing one for child and parent. Children can be relieved of fear and guilt and assured they are loved by both parents. They can find security and even come to accept the total or near total failure of a parent in caring for him or her (Despert, 1962, p. 2). The California-based research of Wallerstein and Kelly (1971-1976) with 131 children of divorced parents indicates that, with children up to about eight years of age, positive adjustment to divorce depended on the state of mind of the parent with whom the child lived. Children who fared best were those who were free to love both parents and develop affectionate relationships with stepparents. It seems apparent that divorce itself is not a crucial factor in determining a child's adjustment; rather, crucial factors are the degree of instability in the child's daily routine, the relationship between parent and child and the meeting of the child's developmental needs.

Children's Perceptions and Reactions Few children feel prepared for their parents' separation; many are shocked. An older child probably feels a range of emotions, all hard to manage: confusion and fear of physical abandonment by the parent who leaves the house (particularly if this parent does not later visit often or at all) and emotional abandonment by both parents if they are distracted. The child is likely to feel rejected. "Why would Daddy (Mommy) leave if he (she) loves me?" or "Why doesn't Mommy want me with her?" The child may continue to feel responsible, not only for the discord of the emotional divorce, but now for the separation as well. The child may also feel victimized, feeling that this separation has been forced upon him or her, and worried about the changes that follow the separation.

Many children regress to earlier stages of development (particularly in toileting, sleeping and eating patterns); some develop physical symptoms or continue with those apparent during family discord; others become withdrawn or hostile (especially toward those "safe" friends or acquaintances outside the immediate family) toward whom such a risk is more possible than it is with parents. Adopted children are especially vulnerable to their adopted parents' separation, having experienced separation previously from biological or foster parents; a rejected, then chosen, child can feel rejected again.

The findings of Wallerstein and Kelly as to age-related reactions to divorce (1980) are of major importance. They describe fear and bewilderment among the 3- to 5-year-olds, focusing on the thought that the departing parent had replaced them; greater capacity to understand the meaning of divorce among the 6- to 8-year-olds, coupled with pervasive sadness and inability to obtain relief; an emphasis on mastery and achievement among the 9- to 12-year-olds as well as feelings of moral indignation and outrage; and feelings of loneliness and fear of isolation among the 13- to 18-year-olds who equated divorce with dying and find it disruptive that a parent left them rather than permit them, as adolescents, to take leave of the parents.

Even a very young child is aware that someone is missing from life. If the absent parent was active in caring for the child, this feeling can be very strong, expressed in crying, listlessness, repeated looking at the door or toward a place where the absent parent is remembered to be. Such behavior will soon stop if the parent does not appear and if the parent who is present is demonstrably comforting. If the absent parents visit frequently, a relationship can be maintained even with a child so young.

Strategies for Helping the Child Cope Parents should plan together whenever possible, what they will say to the child and talk to him or her as soon as they know that separation is imminent. While it is probably awkward for separated parents to talk with a child together, planning together will allow for consistency in what the child hears. It will be less confusing for a child to hear a similar version of what has happened and what will happen. Parents often think that a child already knows what is going on and understands it, which is an unrealistic attitude. Children hear but do not understand; they often know that something is terribly wrong, but not what it will mean to them. There are certain things a child must know to feel confident about his or her own future, and parents must talk honestly. Yet children need to know only enough about the family situation to feel secure and cared for. The child needs:

1) to be told that he or she is not to blame, not the cause of separation. "Daddy and I decided that we couldn't live together anymore; it was nothing you did."

2) to be reminded often, through actions and words, of each parent's continuing love, particularly by the parent no longer living with the child. "Mommy and Daddy both love you. Daddy (Mommy) loves you even though he (she) won't be living with us anymore." In the case of that parent who does not love the child, covering up the parent's lack of positive feeling probably will not help the child very much. He or she might be told, "Daddy has problems and doesn't know he is hurting you. What you must remember is that I love you very much and will take care of you." The burden is on the absent parent to prove his or her love because contact with the child is less frequent.

3) to know that the parents understand and are not upset by the child's feelings of anxiety, fear, guilt, sadness or anger. It would probably help to hear: "I know that you are sad (or afraid, angry), and I'm sorry. But this is part of our life and we have to help each other find ways to be happy." The child also needs help in expressing feelings without prying or pressure. "It is all right to talk about how you feel. Talk to me whenever you want to." The child may need clarification: while venting feelings is all right, some behavior is not acceptable. "It's all right to say you are angry, but I will not let you hit me."

4) to know the practical details of what the divorce will mean: where he or she will go to school; with whom he or she will live; when he or she

will see the absent parents; whether Mommy will work and, if so, who will take care of the child.

5) to be assured that the parent with whom the child will live is strong enough, capable of caring for the child. The child's security is resting not only on feeling loved, but on knowing that the mother or father can handle problems, even outbursts of anger.

Further strategies for helping the child cope might include the following:

1) Visitation arrangements flexible and frequent enough so that the child may be less likely to feel rejected or repressed.

2) Help from someone other than parents, help that should be arranged, especially if the parents can say or do nothing to comfort the child or if the child is acting out or is withdrawn. An especially understanding teacher or clergyman can provide help. A psychotherapist or counselor is often necessary.

3) Physical comforting much-needed at this time (holding, rocking, stroking) with soothing words: "I know, I know it is hard. It will be all right."

4) Playthings to encourage a child to play about what he or she cannot talk about.

The child does not need to hear one parent blamed for the separation, though it may be tempting to think of the absent parent as "bad" or irresponsible (Ilg & Ames, 1955, p. 332). The child need not have false hopes raised, once the divorce is certain, that Daddy and Mommy will get back together again (p. 332). As long as the child holds on to such hope, he or she will remain unhappy and not try to cope with what is really happening.

Stage Three: Single Parent Household

Stress Factors In setting up a single parent household, a parent works on two major issues that affect the child: 1) redefining the family, which includes clarifying the difference between spousal relationship and parental relationship with an ex-partner, and 2) redefining oneself in terms of social relationships, especially dating.

Divorced parents and their children are usually defined in the negative: "broken" or "single parent family" (as opposed to household) as if one parent had ceased to exist. In reality, a family can change from married to divorced, from one household with a mother and father present, to two households with a mother as head of one and a father the head of the other (Ahrons, 1980, p. 437) and yet remain a family redefined but whole in its own right, often with the parents still functioning in a strong, positive sense in the child's life.

Divorce marks the end of the legal spousal relationship for parents and is a process of separating emotionally and behaviorally. But parental relationship continues as each partner continues to relate to each other in an interdependent manner and proceeds to develop an inde-

pendent relationship with the child (p. 438). If and how parents continue to share child-rearing functions will significantly influence the effect of divorce on the child. It is clear that a mutually supportive and cooperative relationship between divorced parents is in the best interest of the child; most professionals and parents stress the viability and importance of some degree of shared parenting (p. 439). It is no easy matter for divorced parents to compartmentalize their feelings toward each other and separate spousal and parental issues. Respect for each other's parenting abilities is essential in helping the child; an arrangement acceptable to both can be set up for solving problems as they arise.

Perhaps, as the parent is redefining the family, new social relationships are arising (heterosexual and/or homosexual), which may lead to eventual long-range relationships. This can be a time of contentment for the parent, having a special adult with whom to share and the resultant emotional feeding. It can also be a stressful time: arranging for baby sitters; planning the relationship between this significant other adult and one's child; dealing with the reaction of the child to this adult and to his (her) relationship with Mommy (Daddy); dealing with other, exterior relationships between this new adult and the child's father (mother) and other relatives.

Children's Perceptions and Reactions At this stage a child is dealing with security issues triggered or exaggerated by separation and a feeling of displacement. The older child may be jealous of the new person in his or her parent's life, even though that child may have talked about wanting the parent to remarry. The child may have a change of mind as fantasy comes close to being reality. There is now danger of being displaced by someone the mother or father likes better, so the child may respond by competing for the parent's attention: clinging, crying, demanding, a response which may intensify if the man or woman is staying overnight or is beginning to live with the parent.

Children cannot always cope alone with their wonderings about the parent's relationship with the overnight or live-in person; they cannot always verbalize such wonderings, sometimes because they are embarrassed, sometimes because they are discouraged. A child does, however, respond to the emotional climate created by the parent, be it calm or comfort, edginess or misery. If calm and comfort prevail, the child usually settles in and accepts the circumstances as the new person in the parent's life becomes more familiar.

Strategies for Helping Children Cope

1) It is important to include the child in the new relationship when that relationship is perceived by the parent as being serious, consistent and probably long-range. Including the child in adult conversation, letting him or her know of the child's importance to the parent and taking the child along on occasional adult outings are ways of making it

easier for the child to accept those times when he or she may not be included in adult affairs.

2) Showing affection, playing with the child when the new companion is present also show the importance of the child to the parent.

3) When going out with the new companion, it is very important not to leave the child in the care of a stranger or in a strange place, but preferably with a relative or familiar baby sitter.

4) It may help the child's trust of the new man or women if it is explained that Daddy's (or Mommy's) leaving does not mean that another will leave (Gardner, 1970, p. 122). No guarantee can be given a child except the parent's assurance: "I will not leave you . . . and whatever happens we will deal with it together."

5) If the child reacts disagreeably to the parent's going out with the new companion and repeatedly persists in such behavior, the parent should hold the child for a while with some assuring words: "I cannot allow you to do this. I will be back soon. But you must let me go for a while and let Mrs. Brown take care of you."

6) It is important to tell a child what to expect ahead of time. It is more difficult for a child to discover that the parent has gone out or that someone is staying overnight than it is to be prepared in advance for these events.

7) Playthings continue to be helpful in encouraging a child to express feelings that cannot be talked about.

Strategies for Helping Children Cope with Divorce — the School Setting

The general atmosphere a teacher creates in the classroom should be one of calm, understanding and acceptance; an environment where a stressful life experience is seen as an opportunity for the teacher to introduce, and the child to develop, effective, socially adaptive ways of moving through anxiety and coping, whatever the stressful experience might be. Virginia Axline writes:

> . . . the most important single factor in establishing sound mental health is the relationship that is built up between the teacher and his or her pupils. This is as true in the kindergarten as it is in the high school. It is as true in a traditional set-up as in a progressive program. It is the permissiveness to be themselves, the understanding, the acceptance, the recognition of feelings, the clarification of what they think and feel that helps children retain their self-respect; and the possibilities of growth and change are forthcoming as they all develop insight (1969, p. 140).

Part of the teacher's "homework" for creating such an atmosphere would be continuing study in child development so that the behavior of children of divorce could be measured against a pattern. Is a child's behavior part of the broad range considered normal? It is important for a teacher to analyze his or her own feelings about divorce. Is it wrong? Is the family "broken"? Are children of divorce always the worst behavior problems? Whenever possible, the teacher should encourage a mutual sharing of information with a child's parents throughout the stages of

divorce. Does the child's behavior at home and at school indicate satisfactory coping or that the child needs additional help?

Specific classroom strategies are:

- Making available the time and facility for children to use a wide range of play materials. Although most children play readily and on their own initiative, it might be helpful for a teacher to provide play materials and to facilitate play by suggesting that a young child "be the mommy while Peter is the daddy." A child can replicate real life experiences and "play through" feelings that often cannot be verbalized.
- Holding regular class meetings or councils (Glasser, 1969, pp. 122-44; Dreikurs, 1964, pp. 301-305) as a means of dealing with any stressful life experiences, including the stages of divorce. Each class can work out its own procedural rules, but Dreikurs describes the basic principles: the meetings involve every group member and are held at a definite time set aside for the purpose each day or week; each member has the right to be heard; adult voices are no stronger than those of the children; chairmanship is rotated meeting by meeting; any decisions are made by majority vote and upheld for a prescribed period of time and cannot be changed between meetings. Such meetings have been a successful way of talking about feelings and solving problems even with 3- and 4-year-olds.
- Moving away from stereotypic ways of viewing and describing families, by talking with children about and sharing pictures of, different kinds of family groups. This also involves talking about the changes that can occur in families and how we feel about them (Uslander, 1977, p. 32).
- Using the word "family" rather than "parents" whenever possible, as almost every child has a family. Asking a child if someone from his or her family will be coming to school or drawing a picture of the family has a different and more positive effect than the more restrictive "parents" (p. 32).
- Avoiding uncomfortable and prying questions about a child's home situation.
- Sharing with an individual child or with a group from a variety of materials available about the stages of divorce.

Some of the best include the following:

Books About Divorce for Young Children

Goff, Beth. *Where Is Daddy?* Beacon, 1969. Story for the preschooler.

Grollman, Earl. *Talking About Divorce.* Beacon, 1975. Text for children; text for adults; resources.

Lexau, Joan. *Me Day.* Dial, 1971. A boy hoping to hear from his father on his birthday.

Newfield, Marcia. *A Book for Jodan.* Atheneum, 1975. A father's scrapbook made for his daughter who lives across the country with her mother.

Schick, Eleanor. *City in Summer.* Collier, 1969; *City in Winter.* Collier, 1970. A boy lives alone with his mother in the city.

Stein, Sara. *On Divorce.* Walker, 1979. A young girl's concern that her parents are getting a divorce; text for children, text for adults.

Books About Divorce for Older Children

Blume, Judy. *It's Not the End of the World.* Bradbury, 1972. A girl tries to keep her parents from getting a divorce.

Gardner, Richard. *The Boys and Girls Book About Divorce.* Bantam, 1971. Topics related to stages of divorce, such as: who's to blame, the love of a parent for a child, anger, fears, getting along better with divorced parents, with step-parents, seeing a therapist.

Mann, Peggy. *My Dad Lives in a Downtown Hotel.* Camelot, 1973. A boy thinks it is his fault that his father has left and tries to persuade him to come home.

Okimoto, Jean. *Mother Is Not Married to My Father.* Pocket Books, 1979. A girl works at getting used to her parents' living apart.

Richards, Arlene, and Irene Willis. *How To Get It Together When Your Parents Are Coming Apart.* Bantam, 1976. Topics related to the stages of divorce, such as: marriage trouble, during and after the divorce, getting help.

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Dreikurs, Rudolf. *Children: The Challenge.* New York: Hawthorn Books, Inc., 1964.

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Glasser, William. *Schools Without Failure.* New York: Harper & Row, 1969.

Krantzler, Mel. *Creative Divorce.* New York: The New American Library (A Signet Book), 1974.

Solnit, Albert as quoted in "The Children of Divorce," *Newsweek.* (Authors Franke, Sherman, Simons, Abramson, Zabarsky, Huck, Whitman), February 11, 1980.

Steinzor, Bernard. *When Parents Divorce.* New York: Pantheon, 1969.

Uslander, Arlene. "Divorce: You Too Must Pay Child Support," *Learning,* February, 1977.

Wallerstein, Judith and Joan Berlin Kelly. *Surviving the Breakup: How Children and Parents Cope with Divorce.* New York: Basic Books, Inc., 1980.

The Children of Divorce Project (1971-1976) is also described in the following works:

"How Divorce Really Affects Children: A Major Report," *Redbook.* (Shirley Streshinsky, author), September, 1976, pp. 70, 132-136)

"The Affects of Parental Divorce: Experience of the Child in Early Latency," *American Journal of Orthopsychiatry.* (Kelly and Wallerstein, authors), January, 1976, pp. 20-32.

"Divorce Counseling: A Community Service for Families in the Midst of Divorce," *American Journal of Orthopsychiatry.* (Wallerstein and Kelly, authors), January, 1977, pp. 4-22.

A Record About Divorce (for younger children)

Goff, Beth. *Stories To Help Children of Divorce.* Caedmon, TC1362.

16mm Films About Divorce

Children of Divorce—Transitional Issues for Elementary School Age ($345; rental fee per day, $35.)

Children of Divorce—Transitional Issues for Junior High and High School Ages. ($345; rental fee per day, $35.)

Both include vignettes and can be stopped for discussion after each; designed to be used directly with children; reactions of children are highlighted. Send to: American Personnel and Guidance Association, 2 Skyline Place, Suite 400, 5203 Leesburg Pike, Falls Church, VA 22041 (703/820-4700)

Family Stress and Child Abuse

MARY E. WOLFGANG

Acute family stress is often an impetus for striking out at a powerless child. Described here are the characteristics of children who tend to be abused and characteristics of parents who tend to abuse their children. Also discussed are society's contribution to child abuse, the resulting impact on the child, and strategies for intervention that the educator can use.

In recent years, child abuse and neglect cases have become a matter of national concern, over a million being reported every year. About 2,000 children die and about 6,000 have permanent brain damage (Kempe, 1976). Basing findings of a national study of violence among family members, Richard Gillis and Murray Straus concluded (1979, p. 15):

"With the exception of the military, the family is perhaps the most violent social group, and the home the most violent social setting in our society. A person is more likely to be hit or killed in his or her home by another family member than anywhere else or by anyone else."

Family members strike out at one another for many reasons, including stressful factors emenating from within, from their interactions with one another and pressures from the larger society.

During the years of raising young children, the family is most vulnerable to stressful influences, which include financial problems, lack of preparation for parenthood, changing adult identities and sometimes social isolation where there is no emotional support system. One or more of these factors may become the final straw, resulting in physically striking out at other family members. The most powerless victims of family violence are usually the children, who become abused or neglected. Blair and Rita Justice (1976, p. 87) estimate that only about one out of a hundred of the actual instances of child abuse and neglected is reported.

Garbarino's definition of maltreatment (1980, p. 7) provides the basis of our understanding of these terms: "We define maltreatment as acts of omission or commission by a parent or guardian that are judged by a mixture of community values and professional expertise to be inappropriate and damaging."

What are factors contributing to abuse and neglect of children? Some factors are related to the child, some to the parents, others to outside environmental pressures.

Family Stress and Child Abuse

Contributing Factors	Impact on Child	Invervention	Prevention	Educators' Roles
Child		*Child*	*Parents*	*Child*
low birthweight	death	health services	parent education	identify the abused child
malformation	failure to thrive	support teams	high school	support child emotionally
mental retardation	behavior problems	pediatricians	pre-natal	provide stable relationships and routines
hyperactivity	mental retardation	public health nurses	post-natal	refer to qualified professionals
crying	learning problems	*Parent*	child development	*Parents*
inability to bond	low I.Q.	family therapy	behavior management	provide information on child abuse through PTA and public information programs
evokes negative response	low self-image	social workers	institutionalize support e.g. parents anonymous	provide parent education on child development, behavior management, stress management
Parent	passive/aggressive	parent education on behavior management and child development	daycare	model non-corporal forms of discipline
abused as child	fearful	support systems	family planning	provide the space and opportunity for parent support groups
low self-image	suspicious	develop coping skills	*Society*	*Society*
views child as an adult	"pint-sized prostitute"	*Society*	ban corporal punishment	Become public advocates for children's rights
lacks child development info.	later delinquent/ and criminal behavior	identify abused children	eliminate poverty	Raise public awareness
lacks behavior management info.		uphold the law	mass media education	
low tolerance		raise social awareness (mass media)	network system to reduce isolation	
maternal overload				
Society				
accepts corporal punishment				
children's rights unrecognized				
social isolation of families				
limited support for families by institutions				
poverty				

Children's Characteristics Related to Maltreatment

Giovanni (1978) has reported that certain physical characteristics are more often associated with abused than with non-abused children, such as low birthweights and physical malformations. Inglis (1978, p. 72) noted that the child's body shape was described as "provocative" by some abusive parents.

Behaviors such as crying, hyperactivity and inability to give to or elicit from the parent a satisfying response were often related to parental abuse.

Intellectual attributes of children associated with child abuse include mental retardation and low IQ (Justice & Justice, 1976, p. 59). Inglis (1978) reported that the abused child's behavior often reminded the parents of negative qualities in themselves or in their own parents, who may have been abusive to them as children. Giovanni (1978) noted that these characteristics of children contributed to a negative relationship with the parent but could not be considered the determining factor.

Parents' Characteristics Related to Abuse

Research indicates that abusive parents often were abused themselves as children (Gillis, 1979, p. 29). In repeating behaviors modeled for them by their parents, they often have low self-esteem and may project that negative feeling onto the child (Inglis, 1978, p. 71). Very often, abusive parents have inadequate understanding of the normal development of children and, consequently, expect the young child to act like a little adult.

> Little Polly Flinders
> Sat among the cinders
> Warming her pretty little toes.
> Her mother came and caught her
> And whipped her little daughter
> For spoiling her nice new clothes.

Thus, in the nursery rhyme, Little Polly Flinders was behaving appropriately for a 2-year-old who likes to get into messy things. However, to a mother who expected more adult behavior, such messiness would be infuriating. Parents of young children make such comments as, "He kept us up all night crying, just to get even." They are attributing more mature motives to the child than the young child is capable of having. Parents may be emotionally immature and needy themselves; in a sort of role reversal they look to the young child to nurture them instead of the other way around (Elmer, 1979, p. 63).

Parents likely to abuse their children usually lack adequate knowledge of behavior management and discipline techniques. Physical punishment is their first and foremost line of control.

> There was an old woman who lived in a shoe;
> She had so many children she didn't know what to do;
> She gave them some broth without any bread;
> She whipped them all soundly and put them to bed.

Like the old woman in the nursery rhyme, many parents don't know what to do and are unaware of alternative approaches to managing children's behavior. Quite often, a parent's response to a biting child is to bite back, so the child won't do it again (Elmer, 1979, p. 64).

A low threshold for stress and frustration has been demonstrated in abusive parents. Inglis (1978, p. 73) notes that mothers who abuse their children are depressed and suffering from maternal overload; too many children, marital discord, illegitimate babies, financial strains and isolation from family community.

Society's Contribution to Abuse

The major problems in our society today contributing to child abuse and neglect include: 1) poverty, 2) unemployment or overemployment, 3) social isolation of families, 4) highly transient life styles, 5) lack of recognition of the rights of children, 6) cultural acceptance of corporal punishment and 7) limited help for families in crisis (Garbarino & Gilliam, 1980).

Both low income and unemployment are related to abuse and neglect. Families with low income (less then $6,000) are more likely to be abusive than those with higher incomes (Gilles, 1979, pp. 30, 31). In homes where husbands are unemployed or underemployed, the rate of abuse towards children is higher than in homes where the husband is employed full time (Justice & Justice, 1976, p. 91).

Social isolation has been found to be a prominent factor. Abusive parents lacking emotional ties with extended families do not enjoy community support, an isolation that may result from a transient life style. Moreover, the American value of privacy contributes to social isolation, a factor related to maltreatment.

Cultural norms contributing to abuse, in addition to the family's right to privacy, are: social acceptance of corporal punishment and lack of articulation of children's rights.

Parents are expected to control their children and teach them to behave in socially acceptable ways. Corporal punishment is advocated in bestselling books for parents, such as *Dare to Discipline*, by James Dobson (1970), who advocates: ". . . spanking . . . of sufficient magnitude to cause the child to cry genuinely" (p. 73); He says: ". . . firmly squeezing a specific neck muscle to cause pain . . . (p. 26)" and ". . . firmly thumping toddlers on the head or rapping them on the fingers (p. 46)." It is perfectly acceptable to slap one's child in the supermarket, in a friend's home and even in church. Also, schools have the legal right to inflict corporal punishment on children.

Although occasional spankings could not legally be classified as child abuse, the social norm of violence as an acceptable expression in family relations paves the way for physical punishment as the first rather than the last resort in resolving parent-child conflicts (Garbarino & Gilliam, 1980, p. 219).

The question of children's rights is hazy. Child advocacy was an outgrowth of the Society for the Prevention of Cruelty to Animals (SPCA) in the late 19th century (Justice & Justice, 1976, p. 86). Until that time, no group had worked for the prevention of cruelty to children. Garbarino & Gilliam (1980, p. 216) call for the development of a social conscience that recognizes children's rights: "Without a concept of the child's right to nurturance and integrity (freedom from violation), there is no way to even define abuse and neglect as a problem."

Impact of Abuse and Neglect on the Child

Maltreatment of children and children's perceptions of such treatment range from extremely severe to extremely mild. On the less severe end, children may perceive physical punishment as a manifestation of caring by the parents, especially in families where affection is also vigorously demonstrated physically.

In the most severe cases of child abuse, death is the result for thousands of children annually in the United States. Tens of thousands

more suffer permanent brain damage and 60,000 more have significant injuries each year. Giovanni (1979) reported some additional specific results of child abuse: the failure to thrive syndrome, mental retardation, lower IQs and learning problems.

Children who have been abused often demonstrate either more passive or more aggressive behavior than non-abused children. Fear, suspicion and hypervigilence characterize their manner of relating to others. Abused children often have poorly developed speech, which may result partly from the dangerous consequences of speaking out to parents and also from a poor quality of verbal interaction with parents.

Some children who have been removed from abusive homes are described as "pint-sized prostitutes: solicitous, smiling, endlessly agreeable" (Inglis, 1978, p. 87). But these children usually have great difficulty establishing strong, trusting relationships with adults. Major psychological effects on children who have been abused or neglected include poor self-esteem and a "marked incapacity to enjoy life" (Martin & Beezely, 1976, p. 108-110).

Solutions to the Problem of Maltreatment

Solutions to maltreatment problems can be viewed in terms of the *immediate* goal of practical intervention programs for children and parents in crisis now and the *optimal* goal of prevention. The first step in intervention is identification of an abused child, which is usually done through medical facilities or in educational settings; or by neighbors or relatives. During the last ten years the public has become more aware of child abuse as a problem; in 1975, the Child Abuse Prevention and Treatment Act was signed. But public awareness needs to be raised even higher through community education and the mass media.

Research has indicated that when health service teams—including pediatricians, public health nurses and lay home visitors—have intervened with families identified as high risk (having several of the previously described characteristics), the incidence of severe child abuse was significantly lessened (Gary *et al*, 1979, p. 138).

Group therapy with parents who have clearly been identified as abusive has been effective in changing behaviors. Therapeutic intervention usually takes an average of two years to produce significant changes in parental behavior. Caseworker counseling by social workers is another form of intervention with abusive families.

Parent education about realistic expectations for child behaviors at different ages as well as individual differences would suggest (or provide) child management strategies for parents whose information on these vital topics is usually limited or incorrect.

Linkages to the community need to be provided for abusive parents, who are usually isolated from the support of others outside the home and unable to establish their own support system. Home visits by social workers and public health nurses can provide such structured links. As

they begin to gain more control over their lives, parents can begin to reach out themselves to self-help groups and other community support.

Davis Gil, who conducted a nationwide study of child abuse, made the following recommendations for prevention: 1) ban corporal punishment, 2) eliminate poverty, 3) provide family planning services, and 4) establish National Health Care centers (Thorman, 1980, p. 159).

In the belt-tightening economy of today, these recommendations may be unlikely of realization in the near future.

Some experts recommend intrusive networks into the family from the larger society. Kempe (1976) has proposed a health visitor system similar to those in Britain, Finland and Sweden. Such a system would be compulsory and universal, employing successful mothers to visit new parents in the stressful months after birth. Garbarino (1980, p. 230) proposed providing: 1) family support services in times of crisis, 2) special services to parents who can be identified as high risk for abuse, and 3) support systems to strengthen the family (i.e., health care systems, neighborhood systems and self-help groups). Additional support programs proposed to reduce stress would include family planning programs, day care programs and parent education programs.

Parent education is of vital importance for the prevention of child abuse. Even parents who are successful and non-abusive can benefit from parent education, which can provide correct information about child development and accurate expectations of children's behavior. Such education can be extended even to high schools, where students may be afforded real experiences with young children. Parents also need educational courses on *discipline* with special emphasis on the alternative approaches to behavior management, such as: active listening, problem solving, value clarification, isolation and rewards.

Elizabeth Elmer suggests the need for much greater use of the mass media in parent education because it is widely available, clearly beneficial and is not forced on viewers or listeners (Elmer, 1979, p. 69).

The Educator's Role in Child Abuse

On the basic level, educators are one of the foremost sources of child abuse identification, which has been required by law in all states since 1965 (Adams *et al*, 1977, p. 11). Beyond that, educators provide support for both the child and the family in stress and, in the larger community, become advocates for children's rights.

Helping the Child

Support The teacher can provide an adult relationship that supports the child's growth and self-esteem. For the physically neglected child, school personnel can provide resources for additional food and clothing. The abused child can find in the teacher a person who relates to him or her in a tender, consistent way. The teacher needs to relate

empathetically to these children, using every possible opportunity to help them build positive feelings about themselves.

Stability The teacher can give a stable adult relationship during times of family turbulence. Often children formally identified as abused are removed from the home but continue to attend the same school. The teacher's role in this case is to provide understanding, support and stability in the child's uncertain world. Daily routines, affording a dependable certain structure and sameness are particularly important. Disruptive, acting-out behaviors should be expected and handled with understanding but consistent limits.

Discipline The teacher, having the important responsibility of providing alternative forms of discipline, must avoid the trap of using corporal punishment. Some teachers have been heard to justify their paddling children, thus: "It's the only thing he understands." There are forms of limit-setting more effective and rational than paddling. Some methods include: active listening, time out, isolation or class meetings. The teacher can become the model for alternative forms of limit-setting.

Support for Families

Preventive Education Information programs on child abuse, parent education, child development, stress management and alternative forms of discipline can be sponsored by the schools. Parent-Teacher Associations and Parent Advisory Groups can contribute to these education efforts.

A Support Network Encouraging parent involvement in the school helps break down the social isolation that contributes to the likelihood of child abuse. Such involvement includes building into the school structure the time and opportunity for parents and teachers to interact and for parents to interact with each other. Parent support groups, while the child is in school, can be helpful, with a room or lounge area provided especially for parents. Home visits by teachers to parents can build bridges between home and school.

Teacher as a Role Model When parents are encouraged to participate in the classroom, as observers, volunteers or participants, they can observe the teacher as a model of an adult who can use alternative forms of discipline. One parent was amazed that when the teacher flicked the light switch on and off an active, noisy group quieted down immediately. A child listened more attentively to the teacher's whispered directions than when she spoke aloud. Parents visiting the classroom can see how behaviors of other children are similar to their own child's behavior, and thus they may begin to understand their own child better as they observe a group of children of the same age.

Child Advocacy In wider social context, educators as the natural allies of children can be spokesmen for the rights of children who are powerless to speak for their own rights. Schools can become pressure agents

within the local community for improved services to families and children. At the national level, they can press legislators to lend federal support to families and children. Through professional organizations, they can create lobbying groups to speak for children's rights.

Support for Teachers

Teachers, in giving support to needy children and their families, themselves become drained and may need support.

Teacher centers have recently become places where teachers learn to express and channel their own stress through relaxation techniques, physical exercise and sharing of mutual concerns. Staff development programs provided by many schools offer more ways for teachers to reduce stress and re-invigorate themselves emotionally and intellectually.

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DIRECT EXPERIENCE

External Factors: Family Environment — Birth or Adoption of Sibling

"Who Am I Now That Someone Else Is Here Also?"

STEPHEN B. WOODS AND ROBIN F. WOODS

When a new child enters the family, whether through birth or adoption, we expect existing children to share parental joy at the coming of the new child or at least to adjust quickly. Described here is the radical impact of a new child on existing children and the total family system.

Someone once said, "Each of us wants to be an only child," which is to say that each of us at some level as children (and as adults) wants our parents all to ourselves. A recent conversation with a 4-year-old revealed that she was trying hard to figure out, in the amazing time-warp sense that only young children understand, what life was like without her older brother. We commonly acknowledge that the older child often shows a dislike of the new baby, but we often forget that the younger child may also like to do away with the older child (or children) to establish the fantasized *only*-child position.

The impact on existing children of the advent of a new child in the family—whether by birth or adoption or foster plan—has been compared to that of a husband's bringing home to his wife a new wife, telling her that he got his new wife because he liked the old wife so much. Our western cultural-value system would make it impossible for us to integrate such a concept, and yet we expect our children to make as difficult an acceptance. When a new child enters the family, whether through birth or adoption, we expect the existing children to share parental joy at the coming of the new child. Even if we have only a little popular magazine knowledge of a sibling's reaction to the arrival of a new sibling, we still expect the existing children to adjust and shape up after a short time. We fail to recognize the radical impact of a new child on an existing child and the total family system.

The classic reactions to the advent of a new child in the family are all around us in the popular child-rearing literature and parents' comments. A young mother says: "Every time my 3-year-old gets near the baby he hits the baby on the head." Stories abound about older siblings' hurting the new arrival. Watch the "loving" older sibling rock the new baby easily at first, then harder and harder until the baby is in danger of falling.

Often the older child suddenly exhibits obnoxious behavior designed to elicit a response, though usually negative, from the parents, whom the child perceives as giving all their attention to this intruder. A delightful preschooler or school-age child can turn into a whining "brat." A "good," well-behaved child may violate house rules or cunningly break treasured toys or household objects as an expression of anger about the new sibling's intrusion.

A less common and more difficult-to-spot change may also take place in an older child's behavior. The bright, normally misbehaving child may become surprisingly "good" in order to win back parents' attention. The child may even slip into a state of depression.

There are "cookbook" suggestions available to the parents or professional child-care personnel to deal with these problems. These suggestions include: planning regular special times with the older sibling; doing activities without the new sibling, which the child particularly enjoys; providing the older child with a milieu within which that child can freely express feelings about the new arrival; accepting those feelings; providing toys, such as a surrogate new sibling doll against which rage can be safely vented.

Such suggestions may provide brief relief for the situation, but the hard realities of our high-pressured life seldom permit harried parents the time needed to carry out a "cookbook" suggestion. In fact, the older child is faced with the painful reality that we must *share* our own relationships, whether we like it or not.

Systems Approach

In recent years those concerned with children's development and education have been devising new ways to focus on the child. One such development is the "system approach." In viewing the family as an interacting system of parts (persons) rather than as a group of individuals, we gain insight into the reason for the hard impact a new child makes upon family members, especially siblings. If, to a family system of three members—Mom, Dad, first child—a second child is suddenly added, the impact is not a simple addition of one more to a group to make four. It is like adding an additional molecule to an existing compound of three by which a whole new substance is created.

The systems approach to understanding what happens when a new member joins the family is especially helpful when the family is functioning as an "open" system. Open systems (Von Bertalanffy, 1968)* have specific characteristics that can help integrate a new part into the whole. Self-regulating open systems are living organisms involved in reciprocity with environment and are steadily moving toward improbable states—toward increased differentiation and higher orders of functioning. In addition, open systems seek optimal stimulation.

In a family faced with integrating a new part into the whole, the old whole ceases to exist if the family is functioning as an open system. The shape and structure of the family are totally altered each time a new member is added; the family structure never returns to its former shape and structure.

*Bertalanffy, L. Von. *General Systems Theory: Foundations, Development, Applications*. New York: Brazileer, Inc., 1968.

The Morgan family were, for example, in August 1979, a unit consisting of five members: father, 58; mother, 53; son, 30; and sisters, 28 and 26. In October brother Alan married Debbie. The following June Betsy married Edward. A year later sister Cindy married Fred. Along with Fred, into the family came his three children from a previous marriage. In December sister Betsy announced that she and husband Edward were expecting a baby in July. In less than 18 months the family system of five had increased to a system of 11 with a twelfth expected. Five persons do not become a unit of 12 without some stress.

This open system has been self-regulating in that the decisions made by each member were personal. The system is involved in reciprocity in that each personal decision within the system has a direct impact upon each element of the system and elicits a response.

When Cindy married Fred she immediately became a step-mother; Debbie, Alan, Betsy and Edward became aunts and uncles; mother and father, instant grandparents. When Betsy and Edward announced their expected child, relationships became even more differentiated: grandparents are now grandparents to both step-children and an expected "own" grandchild: cousins are created. Each individual within the family system is called to further, different roles as it becomes increasingly complex.

In a rapidly changing society, the rate of family change is not extraordinary. Many times the stimulation created by many alterations exceeds "optimal." Here the fantasies develop: when a person may wish to have existed at an earlier point, when the system was less complex, when the oldest remembers nostalgically that he or she was once the only child.

In contemporary social structure that includes many second marriages, where "blended" families combining two previously separated systems is a common occurrence, there is a great possibility of "information overload." This occurs when a system has been fed more bits of data than it can process in a given period.

The "cookbook" solutions do not account for the complexity of stimulation that characterizes information overload. Open systems seek information, reciprocity with the environment. A system that has reached overload closes. No additional information can be processed until a sorting out of the overwhelming data that created the overload is accomplished. Therapeutically, there may be times when a closing of the system, a resistance to reciprocity, may give time for the solid foundation of the system to be replenished. No new information is admitted for a time until the old information is processed. This closing of the system may be "optimal stimulation" for a time.

People come into the world needing stable relationships in order to survive psycho-bio-socially. The status of contemporary family life may be compared to the mechanistic overload. The pace of contemporary society appears to be encouraging a rapid dissolution of formerly stable

relationships. Divorce, separation, loss and rapid acquisition of new relationships through birth, adoption and family blending are commonplace experiences for many children. Such experiences may present children with information overload; those children may become "closed systems" for a time. Closed systems are often in conflict with the environment. Such conflict is often in relation to one's own personal identity and is especially strained when new members join the family. The most frequent conflict is around the issue of : "Who am I, now that someone else is here also?"

The resolution of this conflict in terms of "You are more, now that there is more to the family" is especially difficult to communicate to children, for such communication, ironically, often precipitates or increases information overload. Consistent, patient and repeated sorting out of such difficult data between adult and child (even when the adult thinks that this information has been covered many times before) can help the child begin to cope with the challenge confronting him or her. Through this kind of support, children can be helped to realize that one of the more interesting prospects of being human is that each new relationship offers the chance of becoming a more differentiated, higher-functioning self.

Student Stress in the School

CHARLES H. WOLFGANG

The role of the teacher is described in helping children deal with their emotional and social needs in the classroom.

The problems associated with forced school integration, family mobility, changing family styles, increased multi-cultural and ethnic diversity have had a direct impact on children and their ability to perform well in school. The teacher's role has, therefore, changed dramatically from the narrow focus of teaching the mental skills required for reading, writing and arithmetic to a wider, holistic view, which involves helping directly with the social and emotional needs of students. Many teachers wish to widen their role to become "helpers" or mediators for children who might be in stress. The teacher techniques to follow can help to enlarge the classroom teacher's "sphere of competencies."

It is important to recognize that a teacher is only one of many helping individuals with unique competencies. Others must include school counselors and psychologists and the personnel of local mental health clinics, psychiatric clinics or hospitals. As there are always likely to be some children in crisis, whose needs extend beyond the teacher's skill or competencies, it will become necessary to seek help for these children from other child specialists with the authority and responsibility of protecting students in ways that exceed the classroom teacher's purview.

"How much help should I give and in what form?" The teacher needs an answer to this, as the response must be based on the nature and degree of the crisis and the child's own abilities to deal with the problem and associated stress.

The four following situations are given as examples of crisis conditions producing stress for students in the classroom.

Situation 1: Physical Injury—Carol

This morning Carol limped into the classroom with a pained expression. When you approached her she pulled away, asking to be left alone. You noticed a large bruise running along her chin and neck. Upon questioning her softly, you learned that her body has bruises of varying sizes, especially on her back and legs. There are penny-size burn marks in the palms of her hands that appear infected. Is this a crisis? If so, what would you do?

Situation 2: Loss of Home/Fighting—Tommy

Tommy, a high school senior in your homeroom, was involved in a fight in the cafeteria today. On investigating, you discover that Tommy, whose record shows him to be an average student with no previous

school problems, had left home the previous month following a fight with his father; the father had come home drunk, having lost his job held for 15 years. After a physical fight with Tommy, the father accused the boy of being "lazy and no good" and ordered him out of the house. Tommy had been living at his sister's since, sleeping on a makeshift bed in her kitchen. Last night the sister's children were ill and kept him from sleeping. He awoke late for school, which required him to report to the office for his tardiness. Having forgotten his lunch money, he managed to borrow from a friend. As he was standing in the cafeteria line, patiently waiting his turn, exhausted from lack of sleep and hungry, another student pushed in front of him. He pushed back and a fight ensued. The teacher attempting to stop the fight was accidentally struck in the face by Tommy; the teacher's glasses were broken. The school has an automatic three-day suspension rule for fighting in school. It is also rumored that Tommy was involved last week in "shaking down" or extorting money from the younger children. As Tommy's homeroom teacher, what would you do?

Situation 3: Queen of the Christmas Dance—Beth

Beth, an enthusiastic "A" student, has for two weeks been inattentive and listless. She has failed a major exam, has not completed any school work during this time. When questioned, Beth says she hates school; she reveals that she has broken up with her boyfriend. Further, this occurred three weeks before the Christmas school dance, for which she had been elected Queen of the Christmas Ball. Her parents, at some hardship, had bought her an expensive dress for the occasion. As Ball Queen, Beth must have an escort to lead the procession. She has been known as "Bill's girlfriend" for a long time; no other boy has asked her to go to the dance, although her having "broken up" is generally known. Beth's final concern is that within a few days she must take a national examination in applying for a college scholarship and for college admission. If Beth's situation is a crisis, how can you handle her stress?

Situation 4: Gifted Child without Friends—Anneta

Anneta, new to the city, did not enter school till February. As the district is involved in busing for desegregation, she is bused more than an hour each way to an upper middle-class white suburban area. She is bilingual, from a large but reasonably affluent Chicago family, and is the only Hispanic child in a classroom of primarily white students with less than a quarter black children. It is now March and she has yet to make a new friend. Once, in the cafeteria she was the brunt of a racial slur. Her past records show her to be a gifted student with an IQ of 180 and almost straight A's. Her grades are now C's and D's, although her homework is always finished. Also, she is often caught sleeping in class. Is this a crisis? If so, what would you do?

When confronted with such situations, teachers are challenged to make sense of them, then make a logical decision on a plan of action.

Making sense requires organization of the facts at hand. There are some theoretical constructs that can help in clarifying and organizing the facts.

Stress occurs for the student (or anyone) when needs are not being met. These needs can be viewed from a Maslowian (1970) construct with regard to physiological, security and esteem needs, belonging and the attainment of self-actualization. To gain self-fulfillment or to become self-actualized, the person's lower needs must first be met—*physiological* needs of food and basic physical health care. Once these needs are obtained, we can focus our energies on *security* and attempt to establish a safe, dependable climate for functioning. Situation 2, Tommy, might be an example of this blocked need.

After security, the next hierarchical need is *belonging*, the need to be a member of a larger group, such as having friends and family, being an accepted member of a class or school. In Situation 4, Anneta's stress might be the result of this blocked need. In Situation 3, we would see in Beth's stress the need for *esteem* and for the degree of respect given by one's peers.

With the attainment of the first four levels—basic physiological needs, security, belonging and esteem—the student can obtain the fullest potential for self-actualization. School structures—grading, grouping, competition and rules—can then be regarded as to how they facilitate or inhibit each student in obtaining a self-actualization position. Difficulties concerning the lower needs often involve life-threatening situations, but blocked needs at every level produce tremendous anxiety as real and severe for the student as stress itself.

There is no clear separation between home-society crisis and school crisis. What occurs outside the school impinges upon the school in the form of the student's poor performance or poor functioning; conversely, what happens in school can create a negative impact on home-society settings. The teacher faced with non-productive student behaviors must help the student respond positively, no matter what the problem's source might be. The teacher's obligation is to assist when the student is in a real crisis and to mediate the degree of help provided, so that the problem-solving abilities of the students are not weakened. Students need to work at their own problems, yet teachers should not abandon youngsters when they are helpless in dealing with their crises.

The Crisis Signals Checklist (McMurrain, 1975) can be modified to fit the behavior of students in a classroom. Finding one "yes" in every one of the four signal categories or several affirmative responses in the subcategories would indicate strongly that a crisis does exist.

With a Maslowian construct to view blocked needs should a crisis occur, we are now ready to evaluate the seriousness of the crisis, then to suggest teacher techniques or helping behavior for assisting the student.

Crisis Signals Checklist

I. Precipitating Stress

Yes/No a. Has there been a specific unexpected shock or strain for the student (e.g. family member dies, an accident, or violent incident)?

Yes/No b. Has there been a prolonged stress that has exhausted the student's strength (e.g. carrying heavy adult responsibilities, prolonged illness, or general neglected nutrition or health)?

Yes/No c. Is the student going through a developmental transition in life (e.g. new baby in the family, changing schools, neighborhood, and/or friends, or dramatic physical growth or body change)?

II. Disruption of Normal Functioning

Yes/No a. Is the student member irrational or illogical, or is he or she unable to make and execute plans to solve immediate problems?

Yes/No b. Is the student losing control of his or her emotions or are his or her emotions inappropriate?

Yes/No c. Is the student's behavior bizarre or strange, or do we see drastic changes in the way the student normally behaves, or is that behavior irrelevant to the problem at hand?

III. Significant Long-term Consequences

Yes/No a. Is something happening to the student that significantly endangers the student's well-being?

Yes/No b. Will harm occurring to the student now affect the student in the future?

IV. Awareness of Distress

Yes/No a. Does the student recognize that he/she is experiencing a state of crisis?

Yes/No b. Has the student openly asked for help from you or others?

Yes/No c. Is the student emotionally upset (McMurrain, 1975)?

Level of Crisis[1]

The level of crisis can be categorized with reference to the level of harm that can permanently damage or affect the student and the speed at which the crisis is evolving. These can be identified on the levels of a) imminent, b) developing and c) potential.

a. *Imminent Crisis* This level is crisis of the greatest intensity and danger, resulting from shock that leads to a real threat to the child's well-being and demands an immediate response. It is urgent to provide direct intervention or help because the student might already have been involved in, or will be imminently involved in, actions that would have irreversible and harmful effects. Generally, at this level, physiological and safety needs are threatened.

Situation 1—Physical Injury, can be classified as an imminent crisis of the most serious nature. At this point it is less important to be concerned about "how this occurred" than to get immediate and direct medical help for the student's injuries. Possibility of infection could lead to a loss

[1]Special acknowledgment must be given to Thomas McMurrain's book, *Intervention in Human Crisis: A Guide for Helping Families in Crisis*, Atlanta; Humanics Press, 1975. This book applies to family stress and the role of social workers. It was from McMurrain's ideas and from the author's (with Glickman) *Solving Discipline Problems: Strategies for Classroom Teaching*, Boston: Allyn & Bacon, 1980, that the present ideas presented here were formed.

of limb or even death. Also, the child should be removed from danger and placed in a protective environment.

Other examples of imminent crisis would be: student carrying a disease, rape, overdose of drugs, serious falls or accidents, carrying of dangerous weapons, hazing by peers causing a young person to attempt dangerous acts.

b. *Developing Crisis* The developing crisis always involves a relatively serious threat to the student and could, if not solved or dealt with, escalate to the imminent level. The problem is immediate but moderately developing, a factor enabling the student potentially to solve the crisis problem alone. Since the crisis evolves more slowly, the danger lies in the failure of the student's school or family to recognize the signs or signals of crisis. There may even be a callous acceptance of the developing crisis instead of taking action toward dealing directly with the problem, which may be growing into a potential imminent crisis.

Situation 2, Loss of home/fighting is an example of a developing crisis, wherein the child's needs for *physiological* help and *security* are not being assured. One might easily fail to see the petty thievery or fighting as signals of a developing crisis. If Tommy does not find direct help for his problem, this situation could turn into an imminent crisis, with the possibility of having permanent and lasting effects.

Situation 4—gifted student without friends could be categorized as a developing crisis. The student's blocked needs would be identified as *belonging* or even, depending on the student's perception, *security*.

c. *Potential Crisis* As seen in situation 3, the potential crisis level is the lowest in seriousness and intensity, generally occurring typically in students' daily school lives. The consequences usually are not of immediate concrete negative concern nor have lasting effects at the physiological or security level. Potential crisis generally involves higher order needs of *belonging* and *esteem*. Anxiety or strong emotional feelings of a student in a potential crisis situation, however, should not be underestimated. Generally, this stress inhibits the student's ability to deal rationally with a problem process, as the student seems to have great difficulty in finding a way out of a morass, while others, such as teachers, parents or even peers, can see ready and practical solutions for the problem.

If the problem of potential crisis is not resolved, it can grow and gradually become a *developing crisis*, which if allowed to continue untreated may suddenly make a student susceptible to an *imminent crisis*.

In situation 3, Queen of the Christmas Ball, Beth is an example of a potential level crisis. She has been blocked in meeting or fulfilling her needs for self-esteem.

Levels of "Helping"

There are some explicit forms and types of helping actions the teacher can take.

Supportive v. Direct Help The supportive position of the teacher involves establishing an empathic relationship with the student while using minimum, supportive problem-solving techniques. The teacher gives the student maximum freedom, while underscoring a belief in the ability of the student to solve his or her own problem or crisis. In contrast, direct intervention arises from the position that the student, because of the stress produced by the crisis (usually Imminent or Developing Crisis Level), is incapable of cognitive thought or rational actions to respond to the crisis. Because the most serious consequences are likely to occur, the teacher must take immediate action to force the student or others—parents, school or local authorities, to take protective actions on behalf of the student.

Between these two extremes are four steps on a "helping" continuum, from supportive to direct: step 1, relationship-listening; step 2, confronting-contracting; step 3, assertive; step 4, direct.

Stress Behavior and Teacher Techniques

Generally, stress on the student disrupts normal behavior. The student is either aggressive—fighting and showing verbal disrespect—or passive; grades fall suddenly, homework is not completed; teachers and school officials see the student as becoming a discipline problem. Today there are many teacher-student interaction models. (See references: Canter, Glasser, Gordon, Harris, Holmes and Raths.) Some modification of these models and techniques is suggested. These models can be placed within the Steps 1-4 of the helping continuum from Supportive to Direct (Wolfgang, 1980).

Step 1—Relationship-Listening The teacher-student interaction models putting the supportive position into direct teacher techniques and actions would be Thomas Gordon's *Teacher Effectiveness Training (T.E.T.)*, Simon and Raths' Value Clarification and Berne and Harris' Transactional Analysis.

T.E.T. suggests such techniques as "active listening, I-messages, no-loss problem solving, or six steps to problem solving (defining, generating, evaluation, deciding, implementing, and evaluating solutions)." The Value Clarification process suggests group or individual value clarification activities that center around non-judgmental questions of choosing freely, choosing from alternatives, choosing thoughtfully, prizing-cherishing choices, affirming, acting upon choices and repeat choices, which supportively enable the student to rationally reflect and judge his or her own thoughts and actions.

Transactional Analysis (TA) views the misbehavior or nonproductive actions by students as destructive "games," possibly triggered by the feelings of helplessness related to a crisis. These "games" have a learned pay-off of obtaining for the game player negative "strokes" or attention from others. This model enables the teacher

to help the student analyze such "games" and respond in rational ways through questioning to find solutions for problems.

Step 2. Confronting-Contracting The teacher-student interaction models of Dreikurs and Glasser are basically supportive, since each values the relationship between student and teacher as being a key element in behavioral change. These techniques would clearly use more powerful methods of confronting and contracting. Dreikurs would analyze the student's non-productive behavior as a result of misguided motivation to obtain attention, power, even revenge, or wanting to retreat to a state of not getting his or her needs met. Confronting the student with the facts of misguided motivation, then negotiating an agreement or contract by challenging the student to come up with a rational plan to respond to the problem should help the student demonstrate more productive behavior.

Glasser, however, deals with children's motivation, not from a theoretical construct, but simply by accepting the fact that the family or school context is not enabling the student to meet his or her needs. Glasser would confront the student to reflect cognitively on actions. "What are you doing?" "Is it helping?" and "How can you change or take actions to improve the situation?" The agreement established between teacher and student on future actions and behaviors is supportive, not requiring punishment. Both Dreikurs and Glasser would have the student failing to live up to the contract be required to "reap the logical consequences for that failure," although the student would not be subjected to non-supportive punishment.

Step 3 — Assertive Consequences Glasser's techniques would indicate, first, that the child be isolated in the classroom. Continuing failure would lead successively to the school office and the principal; suspension at home, involving parents; to a community health institution or legal organization concerned with delinquencies and rehabilitation.

At this level powerful teacher actions literally force or coerce the development of critical actions to protect or get direct aid for the student with physiological or security needs. Such assertive actions are within the power of teachers, school authorities, legal or professional personnel and, of course, the parents.

In Situation 1 — Physical injury, after assessing the level of physiological need, the teacher responds at Step 3, assertive-consequences, to get help for the injured student. The actions would be (1) direct medical care, (2) future protection for the student.

The model of Assertive Discipline along with others (Smith, 1975 & Alberta, 1978) provides directive techniques in stating demands and following through. If the parent neglects the child's welfare, the teacher can move to the spheres of school nurse, local rescue squads or medical authorities. This "take charge" assertive process evaluates the extreme seriousness in a very sensitive position. If these assertive actions get no

professional response, the teacher then needs to advance to Step 4—Direct Intervention.

In Situation 2—Loss of home, the teacher assessing Tommy's situation as a developing crisis sees that his parents must assume their legal responsibility and provide a secure home. Assertive actions, such as family counseling to show positive resolution of the problem or legal ramifications, would be the promised consequence.

Step 4—Direct Intervention Some crises are so threatening and dangerous to the student that the student, parents or responsible administrator will not or cannot take actions in time to protect the child. In Situation 1—Injured child, if the parent or school official should fail to help, the teacher might take the injured child to a hospital or physician, demanding help.

Since direct intervention would require a force and authority the teacher might not be able to render, it would be helpful to have a school-wide understanding between staff and school officials about cooperative conduct in such situations.

Meetings of school staff and officials could be held to discuss possible crisis incidents involving direct intervention, with an exploration of legal implications and general guidelines. For example, what should a teacher do who sees a student pushing drugs in school or extorting money?

It is the skill of the teacher as a professional to gather, order and assess needed information and determine to put into action the kind of help that does not "steal" learning from the student or weaken future problem-solving abilities. Although such actions involve risk, the teacher in the long run may be in the most ideal position outside the family to render real help when students need it most.

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The Child's Community and the World at Large

RICHARD POZZUTO

Events outside the boundary of the family affect the child's life: floods, famine, war—among other natural and man-made disasters. The effects of these disasters on children are described with suggestions for lessening negative effects.

The child's usual associations are limited to include family, neighborhood and perhaps school, all familiar, somewhat personal, social relationships. While the child's world extends initially to parental figures and only slowly expands to include family, friends and neighbors, the child is always a part of the world community.

Events beyond family interests and vicissitudes affect the child's life—floods, famine, war and many other natural and man-made disasters. These events can produce particularly stressful life experiences for the child. Occurrences, which adults viewing from a distance perceive as social disaster, seem to go unheeded by children. Freud and Burlingham (1943, p.21), when speaking of the bombing of London during World War II, report numerous instances of children arriving at rest centers in the middle of the night from their bombed-out houses, who slept and ate normally and played with whatever toys were rescued or provided for them.

Their apparent calmness is not unique to World War II or London. Kaffman (1977) reports similar findings in Israel after the Yom Kippur war of 1973. The children of the kibbutz were within sight and sound of war, knew of wounded and dead and spent considerable time in underground shelters. Among those who had not lost parents, "there was no increase in emotional difficulties of children during or within two years after the war . . . no increased anxiety reactions, phobic fears, night fear, etc. . . ." Ziv, Kruglansku & Shulman (1974) confirm these findings.

War is not, however, all laughter and flowers for children. Kaffman (1977) also reports that 50 percent of the children between 2 and 10 years of age who lost parents in the Yom Kippur war displayed excessive mourning reactions. Harding & Looney (1977) in reporting on Southeast Asian children in refugee camps illustrate numerous psychiatric difficulties. It seems that certain aspects of war, not war *per se*, are particularly stressful for children.

The work of Bodman (1941), John (1941) and Vernon (1941) provides ample evidence that it is not the sights and sounds of war that distress children. In fact, they suggest that the worst effects on children resulted

from overanxious and hysterical adults. Baider and Rosenfeld (1974) report that parental denial of war and masking of their own anxiety are especially traumatic to small children. War, experienced by the child through the responses of significant people in the child's life, increases stress on the child. We can hypothesize here that it is not the concrete acts of war that produce stress, but rather the disruption of the child's understanding of how his or her particular world works, which produces stress.

The Child's Familiar World

Childhood is a period of growth and creativity, but it is also a period of confusion, distortion and inadequacy. Both Sullivan (in the use of the terms: protaxic, parataxic and syntaxic thought) and Piaget have illustrated the limited conceptual ability of children, which gives rise to a rather private and often false conception of how the world works. A primary function of parental figures is helping the child make sense of the world. As the child's social contacts expand, the sense-making function is shared by family, friends, teachers and peers. If this sense-making process is disrupted the child experiences stress, is thrown back upon his or her own devices to give meaning to emotions, interactions and events far beyond the immediate environment.

Aside from the interactive process, a certain stability and familiarity are important for maintaining meaning. For example, persons arise routinely in the morning. As the child witnesses this routine, an understanding of the world is confirmed. Any change in the routine requires explanation. This same confirmation of stability is served in part by being surrounded by familiar objects.

Adjustments in Wartime

Given this perspective, the findings of Maas (1963) become clear. Maas compared the adjustment of young adults from three British wartime residential nurseries. Nursery A, the smallest, had a child-to-staff ratio of about 10-1. The substitute parenting was firm but not suppressive. Nursery B was middle-sized, with a staff ratio of 5-1. The staff was the most sophisticated psychologically, and there was frequent contact with parents. In nursery C, the largest, the staff consisted of teachers and teacher helpers with little training in psychology. Parental visits were infrequent.

In comparing the reaction of adults who had been in the nursery, Maas found little difference between nurseries A and B, while the residents of C tended to fare better. Results at first glance are somewhat surprising.

Nursery C had some unique features that overcame its lack of psychological sophistication, size and infrequent parental visits. The children in nursery C had all come from the same school. They had been

evacuated from London as a unit, including teachers and helpers. Once at the nursery, the themes of God, King and the wonders of nature were stressed through instruction, songs and ritual. Essentially, nursery C had managed to keep intact significant units of the child's sense-making process; and the peers and teachers were there. In addition, the themes and rituals were a reinforcement of their sense-making of this new world.

Although perhaps unintentional, this same emphasis upon the sense-making process was employed in Israel in preparation for the Yom Kippur war. Kaffman (1977) reports that definite steps were taken to inform children of the process of war and death and to prepare them for the sounds of war. The younger children were organized into games that would help prepare them, such as playing in the dark and rattling windows. In this fashion, the events of war when they came made sense to the children. The element of surprise was lessened, and there was no lack of information for the children. Also, special efforts were made to keep the children's peacetime routine. In this way the familiarity of the child's world remained. With this emphasis upon the sense-making process the psychological effects of the war upon the child were minimized.

Effects of Natural Disasters

Wars which grow out of a historical background, create tensions and stresses, often of long duration. Sudden, unpredictable disasters of natural origin present a different set of problems.

Examples of such unpredictable events would be the nearly total destruction of Darwin, Australia, by cyclone Tracy in 1974 and the Buffalo Creek, West Virginia, flood disaster of 1972.

On Christmas Day, 1974, cyclone Tracy struck the town of Darwin in the Northern Territory of Australia. Between 5,000 and 8,000 homes were destroyed, and in the week following the cyclone 30,000 residents had to be evacuated. Surprisingly, there were only 65 deaths. The psychological toll, however, was heavier.

Milne (1977) compared three groups of Darwin residents: those who had not been evacuated, those who were evacuated and would be returning and those evacuated and were not returning. He found the non-returning group to be the most affected, evidencing an increased fear of the future and an increased use of sedatives, alcohol and tobacco. In fact, 31.5 percent of the non-returning women exhibited measurable emotional disorders, a significantly higher rate than the 12.5 percent for returning women and 10.7 percent for non-evacuated women.

All the residents of Darwin, both adults and children, experienced great stress caused by the disruption of their social world. In effect, after the disaster they needed literally and figuratively to reconstruct their world, a rebuilding that was definitely a group process.

The frequency of social contacts for non-returning evacuees dropped sharply, while the other two groups continued their usual frequency of social activity. This finding suggests that the task of reconstruction would be slower for the non-returning evacuees. They did not avail themselves of the resources of other persons. Instead, they remained relatively isolated socially, left to their own devices to pull their lives together.

Not surprisingly, the children of Darwin demonstrated the same pattern of disturbance. The most affected were the non-returning children, followed by the returning children. The least affected were those children who had never left. Milne (1977B) found these differences to be statistically significant. He also found that within ten months, 45 percent of the emotional disturbances had faded. As expected, the non-returning children showed the least improvement (1977B, p.62). Milne concludes that, ". . . given a situation in which physical violence is threatened from an external and impersonal source, the child's reactions will be largely determined by the social and emotional climate of those he trusts." We can conclude that the children's responses to cyclone Tracy were similar to the responses of children in both the bombing of London and the Yom Kippur war. Again, it is the adult contacts and the sense-making process that affect the child's response to the stressful event.

In considering adults and their responses to disaster, Robert J. Lifton presents clear pictures with his work on Hiroshima (1968) and the Buffalo Creek, West Virginia, flood disaster of 1972 (1976). He found in both incidents a similar pattern of responses. In West Virginia, when a 30-foot wall of water wound down a narrow creek hollow in less than an hour, leaving 125 dead and 5,000 homeless, the image of the event seemed etched in the minds of the survivors, who 30 months later reported they still experienced frequent dreams of the destruction; they tended to think of this ordinarily "unnatural" destruction as a natural part of life.

The survivors experienced guilt over having lived while others died, as well as a psychic numbing. There was a continuing marked incapacity to feel, along with a tendency towards apathy, withdrawal and depression. Under this numbing was an unfocused rage, which almost totally impaired their relationships with others. Although the survivors felt need for family closeness, they were unable either to provide or accept warmth.

The final element of the response pattern points the direction for repair of the psychic damage. All the survivors experienced a struggle to give meaning to what they had lived through. Some turned to the church for an explanation of the disaster; others formed social action groups to pressure the mining company, which was felt to be responsible through negligence for the disaster. This movement grew into an attempt to change the law pertaining to mining safety in the area. In this

way, the survivors, banding together to "fit" the disaster experience into their understanding of the world, felt some good could come from their loss. It was this sense-making process that drew them together where they found mutual support.

Against this background the children of the area grew up. They too needed to give meaning to their experience. Their responses and understanding paralleled the patterns of their parents. To the extent that the parents could reconstruct their lives, the children were less likely to experience long-lasting effects. Sometimes, however, the parents' own needs create a distorted pattern of interaction with the children. This has been studied with survivors of Concentration Camps in World War II as they appeared to use their children to help solve their own problems.

Koenig (1964) found that parents in World War II concentration camps carried on an almost desperate, forced attempt to attain their own identity through their children. The parents expected the child to become an extension of themselves rather than a separate individual. Niederland (1964) and Rakoff, Segal and Epstein (1966) reported that aspects of the survivors' rage were transmitted to the children. This was seen in increased aggressive and explosive behavior when the children reached adolescence.

Barocas and Barocas (1973) report similarly that the guilt of the surviving parents is transmitted to their children. This onus of guilt obliges the child to work through his or her own developmental needs as well as the parent's unrealistic expectations to resolve their feelings of worthlessness. These added pressures are visible in second generation survivors.

In the various types of disasters discussed here the children's responses have been similar. For the most part, their response is dependent upon the attitudes and actions of adults around them. These adults are significant, as we have seen, not only at the time of disaster but for many years afterward.

Although the effects of disaster upon children cannot be totally eliminated, the deleterious effects can be lessened. First, adults must find ways of dealing adequately and promptly with their anxieties in order not to transmit them to the children. Second, children should be given as much information as they can understand and tolerate so that they can make sense of the disaster. When possible, this information should be provided in advance of the event. Third, the child's social world should be kept intact. This means establishing and developing relations with significant adults and peers as well as workable, dependable social routines.

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Media Damage: Developmental Stress Points

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Children are exposed to a variety of media (TV, radio, records, films, print), much of it inappropriate to their developmental needs. In this discussion of the effects of media exposure, adults are urged to deal with the damage that the media cause to our young.

Once upon a time children lived in a world with closer boundaries. The safety and security of their world depended largely upon their families. But that was once upon a time. World War II changed forever the face of innocence. The booming confusion of modern times has exploded along with the atom bomb into the chaotic, pulsating, seemingly out-of-control, unpredictable technological NOW. One day's chaos, from early morning news through bureaucratic and family affairs and readily available media entertainment, might well have filled a week or even a lifetime of shock, distress, anger, even pleasure in the past.

Added to the chronic chaos are economic worries for most families. Under the heavy pressure of economic disequilibrium in distribution of economic resources, adults seem to vent much of their anger with the world and themselves upon the children. Responsibility as decision-makers appears to have become so overwhelming that many adults are expressing strong desires to abdicate their roles. Evidence of this abdication, or perhaps a determination to develop better patterns for today's living, can be seen in the establishment of varied life styles and in the movement to eradicate the boundaries between childhood and adulthood.

Children are not expected to grow up; they are now expected to be grown up. Even 2-year-olds are expected to be decision-makers, sharing in the solutions of serious problems (custody, divorce, housing, welfare) and everyday problems (family management, mealtimes, food choices, clothing, entertainment, bedtime hours). This acceleration, a push for a speed-up in the developmental process, has been accentuated by the growing importance of the media in daily lives.

The level of media-impacted developmental stress experienced by children throughout our society should be a matter of grave concern to all adults. Reports from developmental psychologists indicate that there are problems related to synthesis in thought process and to heavy TV viewing. Audiologists report on damage to the inner ear and increased deafness related to heavy exposure to stereophonic sound. Radiologists are concerned with the long-term effects on the brain tissue from sitting in front of TV screens. Nearsightedness is reported to be increasing in younger and younger children. Sociologists are actively engaged in the

testing of hypotheses related to the role played by the mass media in speeding up socialization processes and encouraging aggressive behavior. Educators are faced with daily evidence of increased power of the media in the shaping of the minds of growing children, seemingly superceding planned curricula.

One measurable aspect is school performance. Lower scores were reported on SAT, GRE and National Achievement tests over the past 30 years. In a recent analysis of the California Achievement Test given in 1980, scores were correlated with hours of TV viewing of students. A correlation appeared between higher TV consumption and lower reading scores, with heavy-viewing, middle-class children showing the greatest drop in achievement by 12th grade. As time needed for refining and testing the developmental processes is accelerated, the child is likely to be left with incomplete and damaged abilities. Imbalances occur as social development outpaces the cognitive. A child exposed to continued media material on social disorder or brutality may be hard pressed to formulate a healthy moral sense by age 12 or 14. Have we not a reason to ask, are children suffering from media damage?

The Family and TV

While a child's school performance reflects both cognitive and social development, requiring guidance and participation by both parents and community, the influence of the media in the developmental areas has not been adequately defined. This influence might properly be studied in the context of the home, the primary agent of development for the young child, since television viewing in an overwhelming number of homes occupies a great part of both adult and child's waking time.

Whatever the composition of the child's family setting, whether a large family or one parent, there is generally one constant member a child can count on, the television set, offering the warmth of familiarity and dependability. Though a machine, it functions as a family member exerting pressure sometimes stressful. *How* TV is used in the home by family members (adults and children) has not been studied as thoroughly as TV program content, mainly because such studies necessitate intrusion into the life styles of adults and children. Still, family patterns in TV usage are known to affect the way the child sees and understands TV content. The adult's way of relating to TV and integrating it into the family structure may be damaging or helpful not only to the strength of the family but to individual members as well.

Many parents using TV as baby sitters have themselves been reared in the television generation. Can this shift from human to electronic babysitter be damaging? What are some implications?

Infants as young as several weeks are set before the TV screen, their attention commandeered by an electronic device. The possibility of developing interpersonal human contact is thwarted as they learn to watch a mini-world of two dimensions wrapped in strong sound, heard

constantly from the time of waking to the time of sleeping. Infants begin to acquire skill in tuning out in order to fall asleep. The stress created by continuous sound and movement on infants and toddlers has not been evaluated, except that we do know that some 3-year-olds in nursery settings are observed as "tuned out." Children appear to respond minimally to what a nursery program offers, often demanding a great deal of attention from others. They are learning how to attend to machines, not interact with persons.

The length of time children watch is frightening. Preschoolers watch 54 hours a week, school-aged children approximately ten hours less. Much of this time is spent alone, with control over the program and length of time of viewing exercised by the child. What children watch moves into their reservoir of experience, experiences selected by them, frequently randomly chosen, responding to no felt need, answering no outer-directed questions; experiences unconnected to past experiences and not directed to future experiences. When children as young as two being "watched" by TV are provided with the power to switch a set on and off, change programs, listen or not listen, something awesome is occurring. Stress is being created as the child learns how to manipulate a machine in order to achieve instant gratification and absolute control of action. Stress is also created when the child is handed a different set of rules as adults or older siblings come home and take over the management of the TV.

There is some stress for parents when they must decide between engaging in an activity with their children or letting them watch TV. Relief offered parents by TV is a bonus in many homes, making it possible to cook meals, have adult conversations and sleep late on a non-workday morning. But something is missed in substituting TV for companionship. The child may not indicate stress, but it is felt in the increased need for parental contact that will one day be understood as loss.

Family fights between adults and children and between siblings frequently center on control of the TV set, often involving childish behavior on the part of adults as they proffer rewards or punishment. The increase in numbers of home TV sets is a result of the scrambling for control of a single set. In multi-set homes, instant personal gratification is available to everyone. Neither sharing, compromising nor abstaining will have to be learned or practiced within the family.

The Child and TV

Educational programs and cartoons are only part of the daily TV fare of children. Young children are experiencing overload in terms of the dramatic content of what is seen on TV. Many as young as three spend the bulk of their viewing time watching situation comedies-dramas, news, game shows and day-after-day soap operas. They cannot sort out, analyze or synthesize the attenuated (dictated by hour and half-

hour time slots) and heightened dramas they see. In the daily news, distrust of authority runs through the program, often inciting fear in the child. It is small wonder that children increasingly show signs of anxiety or are constantly striving to act out violent scenes as they move toward more fantastic modes of activity, as seen in their behavior.

Expectations of family life are being formulated through experiences with TV families. The disparity between "life" as seen on TV and one's own family and personal life is a constant source of stress for both adult and child. Commercials that idealize homes, cars and lawns make it look as if everyone else lived affluently but you. Why aren't your parents as brave and concerned as the Waltons? Why is your dinner table always a mess or your bathroom so small and cluttered? Children do not learn the unrealities of these feelings about TV "life" until long after the effects have taken hold.

The Child, Society and TV

Prior to TV the family provided the strongest models for children under five. After that age the child began acquiring new models in moving from family range to school. With TV the variety of models ranges from superheroes to voluptuous "Charlie's Angels," which at an earlier stage may well conflict with what a family offers or approves. For the young child, their disapproval can be particularly stressful, since it places the unfamiliar and unknown within hourly reach, frequently without parental reinforcement.

Older children involved with soap operas are confronted with a full display of contemporary family problems: incest, drugs, divorce, teenage parenthood, adultery and even murder. Changes in societal norms in personal and family roles are viewed repeatedly by children usually before they are experienced in familiar and more secure settings involving family and friends. As a result, there may be a theatricality, an attractiveness that cloaks the true human condition, facilitating acceptance of social dissonance, creating a ghoulish enthusiasm for tragedies on the part of children.

There may well be a short-circuiting of the specialization process created by the immediacy (in one's home), availability (on demand) and constancy of the TV medium. Perhaps the strongest evidence of the power of consumerism shows up in the increased sale of items used by children, which they have seen on TV. Advertising is now directly aimed at children as consumers, even to sexually suggestive adult commercials directed at the young consumer. The added stress on the family when pressured by children to buy TV-advertised products often extends to the children too when they feel they are being deprived of things other parents buy for their children.

Radio, Records and Reality

Children are heavy buyers of records and they adopt recording artists as models, yearning for success as a singing star. A millionaire by

eighteen! The pressure to emulate such "artists" has led many a youngster to forego academic studies and concentrate on music. The reality of the pop and rock world is incomprehensible to growing children. They are intrigued rather than repelled by the sordid fate of a Janis Joplin or Elvis Presley.

It is not only the attraction of these models for the young that gives parents stress. The language of the pop and rock genre is both frightening and appalling to parents, teachers and younger siblings. Song lyrics are taken as real experiences and used as references for information among teenagers. The meaning of sexually explicit statements is internalized by 10-year-olds, who frequently have no real understanding of what they mean. Sexual overload occurs; a heightened sense of the urgency and centrality of sex is created, leaving pre-adolescents unable to deal with the media-induced stress.

For most children radio no longer plays the role it played before TV, a vehicle wherein children could listen to stories, plays and poetry. Personal stereos and cassettes are replacing radios in many homes. Giant radios with cassette players, small personal cassette players and radios are being bought by youngsters. Such a purchase may add economic pressure, surely causing additional family stress.

Films

The rating system of films currently used is age related. Films are rated X (no one under 17 years allowed), R (under 17 with an adult), PG (parental guidance suggested) and G (all ages). Forty-five percent of all films are rated X or R, with a sizable number rated PG, and a small minority rated G. Children at younger and younger ages are showing up as part of PG and R audiences. As the cost of babysitting rises, more children under five are attending these PG films with parents or older siblings; they are often exposed to adult films with scenes of incredible brutality and violence. Many adults think that young children do not understand the film action and content and therefore will not be affected by what they see on the screen. What are they seeing and how are they incorporating what they see into their reservoir of experiences? Are pressures being created by seeing adults engaging in sexual activity, violence, hearing them use abusive language as part of their conversational speech; observing duping, stealing, and even murdering? Murder itself is often portrayed as a justifiable solution; victims are so evil or ugly or weak that they deserved to die. Is it defensible to place a child in the position of determining whether one is bad enough to be murdered?

Many PG films, such as *Raiders of the Lost Ark, Clash of the Titans* and *Superman I* and *II* depend on extraordinary special effects to convey action, effects so skillfully done that even 10-year-olds do not always comprehend the fantastic nature of what they see. What is viewed appears to be real. The ability to sort out the real from the fantastic is acquired maturationally through experiences that facilitate such learning. When the impossible is shown with such reality, reason is lost and

even adults are hard pressed to sort out the real from the unreal. Children are further victimized as a total consumer-directed apparatus produces toys and games based on such fantasy-based films.

Parents taking young children to a PG film, such as *Raiders of the Lost Ark*, may not consider the developmental needs of their children. The horror of shocking situations—snakes, thunder and lightning—things that are feared by 5-year-olds—can be particularly disturbing. Reason does not exist in such films; children may be *left* with their fears. Such "shockers" and disaster films as *Airport* and *The Towering Inferno* are specifically designed to work on the fears of the audience. Adults can respond to the teasing and tensions of such dramas, but children are neither teased nor satisfied. Their developing sense of security is jolted, damaged, even eroded as they experience an alarming, incomprehensible and catastrophic world.

The Printed Word

Although written communication has taken a secondary role to TV in more recent times, adults still bring newspapers and news magazines into the home. The world is revealed as a scary place through bold-print headlines and lead stories of assassinations of world leaders; kidnapings, earthquakes and volcanic eruptions. If children exposed to seeing the news in print have adults or older siblings to talk to about their fears, they can be relieved of some stress created by such an overpowering world. But, if children cannot count on adults, on the persons who love and protect them, whom can they count on? Who will assuage their fears? Who will help them grow?

Television, films, radio, newspapers and magazines not only reflect the society but have become instruments of society. How adults are using such media should be examined in terms of the developmental effects on the lives of children and direction of such growth.

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"We speak for all the children of all of the nations, all the lands, knowing well that in their common human core is more of likeness than of difference, knowing too that only as we reach that common core in children will men the world over reach it in each other." So spoke Agnes Snyder, an early leader, of the purpose of the Association for Childhood Education International.

Founded in 1892 as the International Kindergarten Union, the organization became the Association for Childhood Education in 1930. The National Council of Primary Education merged with the Association the next year. Membership is open to all concerned with the education and well-being of children. Teachers, parents, college students, teacher educators, pediatricians, day care and community workers and others help make up the membership in 70 countries, mostly in active branches, but also through individual memberships.

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